# **EXTENDED DAY INTAKE**

Dated Completed: \_\_\_\_\_

| I. IDENTIFIC  | ATION INFORMATION |               | (DD/MM/YYYY) |      | (Circle) |
|---|-------------------|---------------|--------------|------|----------|
| Child's Name:   |                   | Birth Date:   |              | Sex: | M/F      |
| If child does not use his/her legal first name, please list the name he/she uses: |                   |               |              |      |          |
| Mother's Name:  |                   | Primary Phone |              |      |          |
| Father's Name:  |                   | Primary Phone |              |      |          |
| Guardian's Name<br>(other than parent if applical                                 |                   | Primary Phone |              |      |          |

### II. SCHEDULE

Please circle the days of attendance:

| Monday   | Tuesday | Wednesday | Thursday | Friday |
|--|---------|-----------|----------|--------|
| Vhat time will your child typically be dropped off at? |         |           |          |        |
| What time will your child typically be picked up at?   |         |           |          |        |

#### III. FAMILY HISTORY

| Marital status of Parents (voluntary information) |  |
|---|--|
|   |  |

Are there any custody arrangements we need to be aware of? Yes / No If yes: Yes / No

Please explain:

If Child is adopted, list age of adoption \_\_\_\_\_\_ is Child aware of adoption? Yes / No

#### Other children in the home (name & ages)

| 1. | yrs | 4. | yrs |
|----|-----|----|-----|
| 2. | yrs | 5. | yrs |
| 3. | yrs | 6. | yrs |

#### Are there other members of the household?

Yes / No

If so, list name, age (if under 21 yrs) & relationship:

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### IV. FOOD/NUTRITION

| What does your child usually eat for breakfast & at what time?  |                      |  |  |
|---|----------------------|--|--|
| Does your child have any special dietary needs based<br>on a medical condition allergies or religion? | Please explain/list: |  |  |
| Does your child have any specific food likes/dislikes?  |                      |  |  |

### V. MEDICAL/SURGICAL HISTORY

| Does your child have any allergies?<br><b>Yes / No</b>  | If yes, please explain: |
|---|-------------------------|
| Does your child take any regular medications?   | If yes, please explain: |
| Yes / No  |                         |
| Does your child have any vision of<br>hearing problems<br><b>Yes / No</b>   | If yes, please explain: |
| Are there any special medical,<br>physical or emotional needs that the<br>school or staff should be aware of?<br>Yes / No | If yes, please explain: |

## VI. PLAY & SOCIALITY

Does your child enjoy initiating activities on their own or prefer a more structured group experience?

What are your child's interests and hobbies?

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How does your child get along with other children or in the same age? How about children of different ages?

What makes your child anxious or apprehensive?

What do you hope will be included in the Extended Day Program?