Apple Blossoms Child Center LLC

Child Profile

So that we may continue to provide your child with the best possible care, please fill out the following where applicable.

NAME:_____ **DATE:** _____

Health Insurance Company:

Group Number: Certificate Number:

Policy Holder:

Medical Conditions and Health Concerns: Include any medication taken on a regular basis:

Allergies:

Physical Limitations: (i.e. Speech etc.)

Siblings: (names and ages)_____

Your child's favorite thing to do:_____

Your child's fear/fears:_____

The things your child dislikes:_____

Has your child previously attended a Child Care Center or group setting?: yes___ no___

If so, for how long? _____

Other Important Information:_____