



HOBOKEN DAY CARE 100  
124 GRAND STREET  
HOBOKEN, NJ 07030  
(201)792-4666  
Hobokendaycare100.com  
headteacherhdc@optonline.net

Infants aged 12 weeks to 2.5 years old \$1075/month  
Children aged 2.5 years old to 5 years old \$925/month

Breakfast, lunch and afternoon snack are included.

Urban League vouchers accepted.

Hours of Operation  
7:30am-5:30pm

After Care available until 6pm for \$100/month

If you have any questions please email or call Suzanne.

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**Child Care Deposit Agreement**

This contract covers the use and purpose of the deposit of \$1075(INFANT PROGRAM)/\$925(PRESCHOOL PROGRAM) provided by the parent/guardian of \_\_\_\_\_ to Hoboken Day Care 100 to reserve a space for said child for \_\_\_\_\_(start date). This deposit is NON-REFUNDABLE(see below).

The purpose of the deposit is to hold a place for said child, guaranteeing a place at the daycare. When the start date arrives, the deposit money will be used toward the child's last month of care at the center. By paying this deposit you agree to enroll your child in the Hoboken Day Care 100 program. If you change your mind before the anticipated start date your deposit is *non-refundable*.

Parents must advise the center at least a month in advance of the child's last day of care so that the center can apply the deposit. If the center must terminate the child immediately the parents will receive back their entire deposit *if current fees are paid in full*. If the current month's fees have not been paid parents will not receive any refund of their deposit. If a parent pulls a child from the program without at least one month's notice they will not receive their deposit back.

By signing this document, the parent agrees to the conditions above.

I, \_\_\_\_\_, understand the purpose and potential forfeiture of my deposit, as described above. I agree to the terms set forth in this contract.

\_\_\_\_\_  
(Parent's Signature)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Daycare Provider Signature)

\_\_\_\_\_  
(Date)

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## APPLICATION FORM

Date \_\_\_\_\_  
Requested Start Date \_\_\_\_\_  
Child's Name \_\_\_\_\_  
Child's Age \_\_\_\_\_ Child's Birthdate \_\_\_\_\_  
Child's Address \_\_\_\_\_  
Parents are \_\_\_\_ Married \_\_\_\_ Divorced \_\_\_\_ Separated \_\_\_\_ Widowed \_\_\_\_ Single

### MOTHER'S INFORMATION

Mom's Name \_\_\_\_\_  
Mom's Address (if different from child's) \_\_\_\_\_  
Home Phone \_\_\_\_\_ Driver's License # \_\_\_\_\_  
Cell Phone \_\_\_\_\_ Email \_\_\_\_\_  
Mom's Employer (include name, address, telephone number and extension)  
\_\_\_\_\_  
\_\_\_\_\_  
Hours of Employment From \_\_\_\_\_ To \_\_\_\_\_

### FATHER'S INFORMATION

Dad's Name \_\_\_\_\_  
Dad's Address (if different from child's) \_\_\_\_\_  
Home Phone \_\_\_\_\_ Driver's License # \_\_\_\_\_  
Cell Phone \_\_\_\_\_ Email \_\_\_\_\_  
Dad's Employer (include name, address, telephone number and extension)  
\_\_\_\_\_  
\_\_\_\_\_  
Hours of Employment From \_\_\_\_\_ To \_\_\_\_\_

### SIBLINGS

Are there any siblings? Please specify name, age and gender.

Name \_\_\_\_\_ Age \_\_\_\_\_ Gender \_\_\_\_\_  
Name \_\_\_\_\_ Age \_\_\_\_\_ Gender \_\_\_\_\_  
Name \_\_\_\_\_ Age \_\_\_\_\_ Gender \_\_\_\_\_

Does your child require medication on a regular basis? (We do administer medication when needed, including nebulizer treatments.)

Age your child began to: Sit \_\_\_\_\_ Crawl \_\_\_\_\_ Walk \_\_\_\_\_

Age your child began to: Talk \_\_\_\_\_

Does your child have any speech, hearing or visual problems?

Do you have any concerns in these areas?

Does your child have any special needs or concerns?

Does your child have any medical conditions that we should be made aware of?

Does your child have any restrictions to play or other activities?

Does your child have any food restrictions? If yes, please list below. If yes, you *MUST* provide the center with paperwork from your doctor stating specific allergies. You must also fill out an allergy form with the office.

Are you concerned that your child may be prone to any type of allergies?

## DOCTORS

Pediatrician's name and phone number \_\_\_\_\_

Dentist's name and phone number \_\_\_\_\_

Please circle any of the appropriate conditions that may pertain to your child:

Does your child have?

Constipation

Convulsions

Diarrhea

Fainting Spells

Frequent Colds

Frequent Ear Infections

Frequent Sore Throats

Lice

Ringworm

Skin Rash

Stomach Upset

Urinary Problems

Worms

Has your child had any of these diseases?

Asthma

Bronchitis

Chicken Pox

Diabetes

Heart Disease

Hepatitis

Impetigo

Measles

Mumps

German Measles

Polio

Scarlet Fever

Tuberculosis

Whooping Cough

Is your child prone to:upset stomach, colds, seasonal allergies, earaches, headaches, sore throats, nosebleeds, etc? \_\_\_\_\_

Do you have a backup plan if your child is ill and cannot attend or becomes ill and must be picked up from school? \_\_\_\_ Yes \_\_\_\_ No

#### PICK UP INFORMATION

Our regular hours are from 7:30am until 5:30pm.

Will you require our aftercare service? \_\_\_\_ Yes \_\_\_\_ No

Time you plan to drop your child off \_\_\_\_\_

Time you plan to pick up your child \_\_\_\_\_

Is there anyone other than mom or dad that will be picking up or dropping off your child on a regular basis? If yes, please provide the name of the person(s) that will be dropping off and picking up and indicate their relationship to your child:\

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

#### CHILD'S HISTORY

Has your child ever been in daycare before? \_\_\_\_\_

What type (center, family daycare, etc)? \_\_\_\_\_

Was it a positive experience? \_\_\_\_\_

Why are you looking for childcare? \_\_\_\_\_

Will you be giving two week notice to your current provider? \_\_\_\_\_

Are there any recent traumatic situations your child has been exposed to such as a death in the family, divorce, new sibling, etc?

\_\_\_\_\_  
\_\_\_\_\_

What language(s) are spoken at home? \_\_\_\_\_

Are there any areas you would like to see your child working on?

\_\_\_\_\_  
\_\_\_\_\_

What is your child's temperament? Are they easy going, hard to please, demanding, etc?

How would you describe their personality? \_\_\_\_\_

\_\_\_\_\_  
What is your normal method of discipline? \_\_\_\_\_

**What are some of your child's favorite activities?**

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**What are some of your child's favorite foods?**

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**If infant, is your child on formula (what type), breastmilk, baby food, baby snacks, etc?** \_\_\_\_\_

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**Child's usual dining habits: (circle all that apply) high chair, booster seat, feeds self, used utensils, bottle, sippy cup, regular cup**

**Are there any foods your child dislikes?**

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**Does your child have any security objects (blanket, pacifier, toy, etc)?**

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**Can your child be relied upon to indicate bathroom wishes?** \_\_\_\_\_

**What time does your child go to sleep at night?** \_\_\_\_\_

**Does your child sleep through the night?**

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**Does your child sleep in a crib, bed, other?** \_\_\_\_\_

**Does your child require soothing to go to sleep (back rubbing, rocking, pacifier)?** \_\_\_\_\_

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**What is your child's disposition when waking up (happy, grouchy, clingy)?**

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**What are your hopes/expectations for your child here?**

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**CHILD'S HEALTH RECORD (A copy of current immunization records will be needed)**

**Are your child's immunizations currently up to date?** \_\_\_\_\_

**General state of health?**

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**PARENT/GUARDIAN SIGNATURE**

**DATE** \_\_\_\_\_

