

Kids First Sitting Service Questionnaire

FAMILY INFORMATION

Child/ren's Last Name: _____ Date: _____

Child's Address: _____

MAJOR cross streets nearest your home: _____

Father/Guardian Name: _____

Mother/Guardian Name: _____

Home Address: _____

Home Address: _____

Cell Phone: _____

Cell Phone: _____

Home Phone: _____

Home Phone: _____

Bus Phone: _____

Bus Phone: _____

Email: _____

Email: _____

EMERGENCY CONTACTS

Contact Name: _____

Contact Name: _____

Home Address: _____

Home Address: _____

Cell Phone: _____

Cell Phone: _____

Home Phone: _____

Home Phone: _____

Other Phone: _____

Other Phone: _____

Relationship: _____

Relationship: _____

CHILD INFORMATION

Child's Name: _____

Child's Name: _____

Child's Name: _____

Age: _____ DOB: _____

Age: _____ DOB: _____

Age: _____ DOB: _____

Routine/Nap Schedule/Feeding Info:

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Sitter will change diapers every three hours (dirty diapers are changed immediately). If you prefer an alternate schedule, please list: _____

List allergies/chronic medical problems of child/ren: _____

Medication required? Yes: _____ No: _____ If Yes, please complete Medication Form.

Pediatrician Name/Address: _____

Dr. After-Hours Phone: _____ Preferred Hospital: _____

Pets (Dogs/Cats/Other): _____

TV ALLOWED? _____ ANOTHER ADULT PICKUP OR DROP OFF?