

We want to provide you with the best care possible. Please help us to get to know your child by filling out this questionnaire. Thank you!

Child's Name: _____ Room: _____

Birth Date: _____ Child's Name: _____

FAMILY DATA

Parent Marital Status: Single Married Separated Divorced Widowed

Household Members: Name: _____ Sibling Age: _____ Relationship: _____

Name: _____ Sibling Age: _____ Relationship: _____

Name: _____ Sibling Age: _____ Relationship: _____

Child's Race or National Origin: Native American or Alaskan Native Asian or Pacific Islander Hispanic Black White

Languages other than English, spoken in the home: _____

Preferred language I want my child to speak at home: _____ At child care: _____

Religious Preference: _____

Culture is made up of factors in the environment, such as attitudes, values, cherished beliefs, ways of doing things, and child rearing practices.

My cultural preferences include: _____

DAILY ROUTINE

Sleeping

Please describe your child's usual bedtime routine (including what time and where he/she usually sleeps):

How do you know that your child is sleepy/tired? _____

Does your child have any difficulties falling asleep? _____ If yes, what is helpful? _____

About how many hours of uninterrupted sleep does your child get each night? _____

Does your child nap? _____ How many hours on average? _____

Does your child sleep with a special blanket, toy, pacifier, song? _____

Do you have any concerns about your child's sleep habits? _____ If yes, please explain: _____

Eating

Does your child generally enjoy eating? _____ Do you consider your child a good eater? _____

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

Is your child on any special diet? _____

List any food allergies: _____

Are there any other food you do not want us to offer your child? _____

Are there any foods from your home/culture that you would like us to offer your child? _____

Do you breastfeed your child? _____ If yes, how often? _____

What does your child eat with? Hands Spoon Fork Does your child eat independently? Yes No

What does your child use to drink? Breast Bottle Tippy Cup Regular Cup

What does your child drink? Breast Milk Formula Whole Milk Skim Milk

Do you have any concerns or questions about your child's eating habits? _____

If yes, explain: _____

Toileting

Does your child wear diapers? _____ If yes, what kind? Disposable Cloth Pull-Ups

If no, does your child use the the toilet regularly? _____ Please explain: _____

Families use a variety of words to describe bathroom activities. Indicate the words your family use for:

Urine: _____ Bowel Movement: _____ Genital Area: _____

Do you have any concerns or questions about your child's toileting habits? _____

If yes, explain: _____

Play

What is your child's favorite toy/object or song? _____

Does your child enjoy playing with others? _____

Does your child do well playing alone? _____

What activities and toys does your child enjoy? _____

Health

Does your child have any health problems? _____

If yes, explain: _____

Does your child take any medication(s) regularly? _____

If yes, please list: _____

Does your child have a chronic health condition or specific health needs? _____

Please be specific: _____

Does your child have frequent Ear infections Diarrhea Constipation

Do you have any concerns about your child's health? _____

If yes, explain: _____

Children in group care may become ill with colds, viruses, etc. several times per year. At times, we are required to ask parents to keep their children out of child care until treatment begins or there are no symptoms. Please see our *Exclusion* policy.

GENERAL DEVELOPMENT

Was your child: Full Term Premature

Is your child adopted? _____ If yes, does he/she know? _____

Describe complications (if any) during pregnancy, the birth process or following birth: _____

Describe any physical or emotional limitations your child has including diagnosis & treatment: _____

Are there any other adults providing services to your child at this time? Yes No

If yes, explain: _____

Do you have any concerns about your child's:

Hearing and/or vision? _____

Speech and language development? _____

Ability to move? _____

Overall development? _____

SOCIAL AND EMOTIONAL DEVELOPMENT

Has your child ever been in group child care? Yes No If yes, type of setting: _____

How does your child respond in group situations: _____

What can we do to help your child adjust to child care: _____

How would you describe your child's temperament and personality: _____

How do you comfort your child: _____

Does your child use a special comforting item: (blanket, stuffed animal, doll) _____

Does your child fear certain things: _____

How is your child disciplined: _____

What works best when you discipline your child: _____

Do you have any questions or concerns about your child's social/emotional development or behavior: _____

If yes, please explain: _____

What educational/developmental experiences would you like us to emphasize with your child (for example, language development, social relationships, kindergarten readiness skills, physical or self-help, etc):

Signature of Parent or Guardian

Date