

ALL ABOUT YOUR CHILD



Child's Full Name: _____ Nickname: _____

I have _____ brother(s) and _____ sister(s). Their names and ages are _____

Has your child been in daycare before? _____ Yes _____ No

If yes, name of Provider: _____

Previous Provider Address & Phone Number: _____

Dates care was provided. From: _____ To: _____

Reason care was terminated: _____

EATING HABITS:

Does your child have a special diet? _____ Are there any foods that should not be served to your child:

If yes, please list the foods and the reason. _____

Your child's favorite foods: _____

Least favorite foods: _____

Does your child eat independently? Yes _____ No _____

For infants, what brand of formula do you use? _____

Does your child require: Bottle _____ Sippy cup _____ High chair _____ Booster seat _____

SLEEPING HABITS:

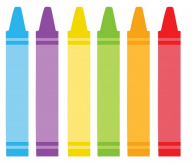
Does your child have a regular bedtime schedule? Yes _____ No _____

What time does your child usually wake up in the morning? _____

What time does your child usually go to bed at night? _____



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Does your child take naps? If so, for how long? _____

Does your child have any problems going to sleep or staying asleep? If yes, explain. _____

HEALTH CONCERNS:

Does your child have any known health concerns? Yes _____ No _____

If yes, please describe: _____

Does your child take any medications on a regular basis? Yes _____ No _____

If yes, list the medication(s), dosage and how often taken: _____

Are there any hearing or vision problems? If yes please describe. _____

Does your child have any known allergies? Yes _____ No _____

If yes, please list the allergy and how it is dealt with. _____

List any communicable diseases your child has had. _____

Does your child suffer from any of the following on a regular basis? (Check all that apply.)

Nosebleeds _____ Headaches _____ Sore throats _____ Stomachaches _____

Seasonal allergies _____ Other _____

BEHAVIOR

How do you reward or discipline your child? _____

Anything else about your child you feel I should know? _____
