LFD&P WANTS TO GET TO KNOW YOU

Childs name: _____ Nickname: _____

I have _____ brothers and _____ sisters. Their names are _____

_____.

How would you describe your Childs personality? _____

_____

_____.

Has your child been in child care before? Yes, or No?

If yes, please give your last provider or centers information.

Name: _____

Phone: _____

Dates attended from _____ to _____

Reason for leaving: _____

_____

Does your child have a regular bed time schedule? Yes, or no

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

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

Does your child have trouble sleeping? Yes, or no

Does your child have night terrors? Yes or no

Does your child have trouble going to sleep? Yes, or no

Other comments _____

_____

All infants must sleep on their back. What is your infants typical schedule with naps and

bottles/nursing _____

_____

_____

_____

If an infant what kind of formula does your baby drink? _____

Are there any special blankets, dolls, ect that your child needs to go to sleep? _____

_____

Does your child refer to any of these items with a special nickname? _____

_____

What is your Child's disposition upon waking? Circle 1 Happy, Grouchy, Clingy, Slow to rise,

Other: _____

Does your child have any know health problems? Yes, or no If yes please describe _____

_____

Does your child need regular medication? Yes, or no If yes what and when is it given _____

_____

(Please note you will also need to have all medication in their original container and a your Childs medical form will need to be signed daily)

Does your child have any allergies? Yes, or no If yes please list allergies

_____

Are there any special instructions in case of an allergic reaction? _____

_____

Has your child had any of the following communicable diseases? Please circle Chicken pox,

Measles, Mumps, please list any others. _____

_____

Is your child prone to upset stomachs, colds, seasonal allergies, earaches, headaches, sore throats, nose bleeds, other? _____

Are there any indications of hearing or vision problems? Yes, or no

Has your child had any recent illness? Yes, or no If yes please explain _____

_____

Does your child have any physical or mental disabilities? Yes, or no If yes please describe ____

_____

Does your child have a IEP or IFSP? Yes, or no If yes please consider suppling LFD&P with a copy.

Do you have a back up plan if your child is ill and cannot attend LFD&P Yes, or no Please describe _____

Do you have a plan if your child becomes ill and must be picked up Yes, or no Please describe _____

What is your Childs eating habits? _____

What are your Childs usual dining habits? Circle all that apply: high chair, booster seat, feeds self, uses utensils, bottles, sipper cup, regular cup, other? _____

_____

Does your child eat unaided? Yes, or no

Does your child enjoy eating? Yes or no

Does your child have a special diet? Yes or no

Due to your Childs tastes, allergies, reactions, and/or religious beliefs are there any foods that should not be served to your child Yes, or no Please list these foods _____

_____

_____

Favorite foods? _____

Strong dislikes_____

How do you reward your child? _____

How do you discipline your child_____

What are your expectation of this program and of me? _____

_____

_____

Would you like a getting to know Katrina meeting? Yes, or no