

## INTAKE FOR CHILD UNDER 2 YEARS – CHILD CARE CENTERS

**Use of form:** This form is mandatory for family child care centers to comply with DCF 250.09(1)(c)1. and for certified providers to comply with 202.08(12)(g). Failure to comply may result in issuance of a noncompliance statement. This form is voluntary for group child care centers; however, it meets the requirements of DCF 251.09(1)(am). This form collects information about children under 2 years of age in order to aid child care workers in individualizing the program of care for the child in a family or group child care center. Personal information you provide may be used for secondary purposes [Privacy Law, s.15.04(1)(m), Wisconsin Statutes].

**Instructions:** This form is to be completed by a parent / guardian and must be on file at the center prior to a child's first day of attendance. Regular updates can be noted. This form should be kept in the room where care is provided. If additional space is needed, attach a separate sheet.

First Day of Attendance (mm/dd/yyyy)

### PARENT / CHILD NAME AND ADDRESS

Name – Child (Last, First, MI)

Nickname (If any)

Birthdate (mm/dd/yyyy)

Name – Parent(s) (Last, First, MI)

Telephone Number – Home

Address – Parent(s) (Street, City, State, Zip Code)

**HEALTH** Note: Health conditions that may affect the care of the child must be recorded on the department's form, *Health History and Emergency Care Plan*. The form should be shared with any person who provides care for the child.

Child has frequent colds, ear infections, colic, etc. – Describe.

UPDATES

### MEALS

Current feeding schedule

Length of time on current schedule

Food type

Breast milk  Formula  Strained  Junior  Table  Milk type – Specify:

New food timetable

When eating, child is –

Held in lap  In highchair  Other – Specify:

Feeds self

Yes  No If "Yes", uses:  Spoon  Fork  Hands

Special feeding problems

Yes  No If "Yes" – Specify:

Food allergies

Yes  No If "Yes" – Specify:

Favorite foods – Specify.

Refused foods – Specify.

UPDATES

**SLEEP**

Current sleep schedule		Length of time on current schedule
Falls asleep easily <input type="checkbox"/> Yes <input type="checkbox"/> No	Mood upon awakening – Describe.	
Takes favorite toy(s) to bed – <b>child over age 1 year</b> <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes" – list toy(s):		
Sleep position – <b>child under age 1 year</b> <b>Note:</b> Children under age 1 year must be placed to sleep on their back unless a written statement from the child's physician is attached. <input type="checkbox"/> Back for children under age 1 year <input type="checkbox"/> Side or stomach (physician statement attached)		
Sleep position – <b>child age 1 year and older</b> <input type="checkbox"/> Back <input type="checkbox"/> Side or stomach		

UPDATES

**DIAPERING / TOILETING**

Diaper – type <input type="checkbox"/> Cloth <input type="checkbox"/> Disposable	Diapers provided by parent <input type="checkbox"/> Yes <input type="checkbox"/> No
Plastic pants used <input type="checkbox"/> Always <input type="checkbox"/> Never <input type="checkbox"/> Sometimes If "Sometimes" – Specify:	
Highly sensitive skin <input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent diaper rash <input type="checkbox"/> Yes <input type="checkbox"/> No
Lotions, powders, or salves used <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", product name(s) – Specify:	
Toilet training attempted <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", describe routine.	
Type of toilet seat used at home <input type="checkbox"/> Potty chair <input type="checkbox"/> Special toilet seat <input type="checkbox"/> Regular toilet seat	
Regular bowel movements <input type="checkbox"/> Yes <input type="checkbox"/> No How often:	Time(s) of day:
Toileting problems <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes" – Describe.	

UPDATES

**VERBAL COMMUNICATION**

Family's spoken language. <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other If "Other" – Specify:	
Age child began talking	Child speaks in <input type="checkbox"/> Words <input type="checkbox"/> Sentences
Words used to describe special needs – Specify.	

UPDATES

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**COMFORTING**

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Does child have a fussy time?

Yes  No If "Yes" – Specify time.

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How is fussy time handled?

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Child likes to be:

Held  Sung to  Rocked  Read to  Other – Specify:

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Special things you say or do to comfort child.

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UPDATES

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**SELF-EXPRESSION**

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What causes your child to feel angry or frustrated?

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What frightens your child and how is it shown?

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How does your child express feelings of happiness, enjoyment, etc.?

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Additional comments

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UPDATES

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**PHYSICAL AND SOCIAL DEVELOPMENT**

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Is your child able to – (Check all that apply)

Sit up alone     Pull up     Crawl     Walk holding on     Walk without support

Yes     No    Is your child used to playmates?

Comments

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UPDATES

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**MISCELLANEOUS**

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Child's favorite **indoor** toys and activities – Specify.

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Child's favorite **outdoor** toys and activities – Specify.

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By providing complete information about your child, you will be assisting staff in creating a positive experience for him / her while in care. List any information about your child's habits, abilities, or personality that you feel will be helpful to the staff while caring for your child.

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UPDATES

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**SIGNATURE** – Parent or Guardian

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Date Signed