



All About Me

Child's Name _____ Nickname _____

I have ____ brothers & ____ sisters, their names and ages are: _____

How would you describe your child's personality? _____

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Has your child been in childcare before? ( ) yes ( ) no If yes, please give last childcare provider, or daycare center's information:

Name: \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Dates attended: from \_\_\_\_\_ to \_\_\_\_\_ Why was care terminated? \_\_\_\_\_

May I contact them for a reference? ( ) yes ( ) no

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Does your child have a regular bedtime schedule? () yes () 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? _____ Night Terrors? ____ Trouble going to sleep? ____ Other: _____

If infant, how does your child sleep? stomach side back

What time(s) and for how long does your child usually nap? _____

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

What is your child's disposition upon waking up? happy, grouchy, clingy, slow, _____

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Has or does your child have any known health problems? ( ) yes ( ) no If yes, describe: \_\_\_\_\_

Does your child need regular medication? ( ) yes ( ) no If yes, what and when is it given? \_\_\_\_\_

Does your child have any known allergies? ( ) yes ( ) no If yes, please list allergens: \_\_\_\_\_

Special instructions in case of an allergic reaction: \_\_\_\_\_

\_\_\_\_\_





Has your child had any of the following communicable diseases? chicken pox, measles, mumps, other \_\_\_\_\_

Is your child prone to: upset stomach, colds, seasonal allergies, ear aches, headaches, sore throats, nose bleeds, other \_\_\_\_\_

Are there any indications of hearing or vision problems? \_\_\_\_\_

Has your child had any recent illnesses? ( ) yes ( ) no If yes, describe: \_\_\_\_\_

Does your child have any physical or mental disabilities? ( ) yes ( ) no If yes, explain: \_\_\_\_\_

Do you have a back-up plan if your child is ill and cannot attend or becomes ill and must be picked up? ( ) yes ( ) no

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What are your child's eating habits? (mind trying new things, times usually eats, etc.) _____

If infant, what kind of formula does your child drink? _____

Child's usual dining habits: (circle all that apply) high chair, booster seat, feeds self, uses utensils, bottle, sipper cup regular cup, _____

Does your child eat unaided? _____ Does he/she enjoy eating? _____

Does your child have a special diet? _____ Due to your child's tastes, allergies, reactions, and/or religious beliefs, are there any foods that should not be served to your child? () yes () no

Please list these foods: _____

Favorite foods: _____

Strong dislikes: _____

Will your child usually eat breakfast here or at home? _____

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What are your expectations of this program and me?  
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