

Infant through Toddler Child and Family Information

Child's Name: _____ **Date of Birth:** ___/___/___

Please complete all of the questions on this form.
The more we know, the better we can care for your child.

What would you like us to call your child? _____

Developmental History:

Type of birth: _____ Complications: _____

Age child began sitting: _____ crawling: _____ walking: _____ talking: _____

Does child: pull up crawl walk with support

Times child is normally hard to please: _____

How do you help your child during these times? _____

Household Information:

With whom does child reside? _____

Who else lives in the home (siblings, extended family, pets?) _____

What does child call family members? _____

Language spoken at home: _____

Does anyone in your family speak a language other than English? Yes No If yes, please list:

Are books read in languages other than English? _____

Are there words in your home language that we should know? _____

Please tell us about any cultural family customs, rituals, traditions, or personal preferences that will help us make you and your child's experience more meaningful: _____

Is there anything you can share that will help us provide culturally responsive care for your child?

Health/ Development:

Serious illness and/or hospitalizations (describe)?

Does your child have any history of colic? _____

Does your child vomit easily? Yes No Does your child run high fevers? Yes No

Does your child have any allergies? Yes No Allergy: _____

Special physical conditions, disabilities, or allergies (describe)? _____

If applicable, I give permission to post my child's allergy in the classrooms and kitchen:

Parent or Guardian: _____

Is your child presently or ever been diagnosed with a special need? _____

If so, is he/she receiving any special services? _____

Does your child take any regular medications? _____

Eating Habits:

Special characteristics or difficulties? _____

Special diet? _____

Any known food allergies? _____

Have solid foods been introduced? yes no

If yes, how much does your child eat at one time? _____

When? _____ How do you prepare them? _____

Favorite foods: _____ Foods refused: _____

Are there any foods your child should not eat for any reason? Yes No

If yes, please explain _____

Does your child have any eating problems (describe)? _____

Child eats: on lap in highchair other

Child eats with: spoon fork hands other

For Infants:

Is your child breast-feed or bottle-feed? _____

If bottle-feeding, how much do you prepare at one time? _____

Please list the child's current feeding schedule (include times and normal amounts):

Time:_____ Amount:_____ Time:_____ Amount:_____

Time:_____ Amount:_____ Time:_____ Amount:_____

Time:_____ Amount:_____ Time:_____ Amount:_____

Sleeping Habits:

Does child sleep in: crib with parents

At home, does child sleep on: back side stomach

Can he or she roll over? Yes No

Times child usually naps? _____ / _____ / _____ / _____

How will we know that your child is tired and needs to sleep? _____

What does your child take to bed? _____ mood on awakening? _____

Does the child like to be taken out of the crib immediately or to lie alone for a few minutes before being held? _____

What helps your child to fall asleep? _____

What time does child go to bed at night? _____ time normally awakes? _____

Are there any sleep/wake time rituals (describe)? _____

Toilet/Diapering Habits:

Is there frequent diaper rash? Yes No cause of rash? _____

Child wears: disposable diapers cloth diapers

Do you use: oil powder lotion other _____

Are bowel movements: regular If so, how often and normal times: _____

Is there a problem with: diarrhea constipation

Is your child toilet trained? Yes No If training, when did you begin? _____
 urination bowels or both
How many bowel movements are typical during the day? _____ usual time of day? _____
Does your child have accidents? Yes No If yes, how often/when? _____

What is used at home: potty-chair special seat regular seat
Word used for urination: _____ for bowel movement _____
Is your child afraid of the bathroom? _____

Social Relationships:

What time will you usually arrive at the center? _____ time you'll pick-up _____
What will help you and your child say good-bye to each other in the morning? _____

Has child had any experience playing with children? Yes No
When with other children, is your child? friendly aggressive shy withdrawn
Prefers to play: alone in small groups with adult
Are there any specific activities your child particularly likes (i.e.: books, singing, climbing)?

How does your child show their feelings? _____
Is your child frightened by: animals loud noises dark storms strangers
 other (please list) _____
How do you comfort your child? _____

How does your child prefer to be held? _____
What method of behavior control is used in your home? _____
Has your child had previous childcare experience? Yes No If yes, did it meet your needs
and expectations? Explain: _____

Partnering With Families:

Do you have ideas that would help us to better support you? _____

What do you, as a family, hope to get out of your child care experience? _____

Are there any needs for which you would like resource information? _____

Do you have any interests or talents you or others in your child's life can share with our center?
Please list: _____

Would you be interested in serving on an advisory committee? Yes No

Parent/ Guardian signature

Date

Staff