

Preschool through School-Age 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:

List any health problems during pregnancy and/or delivery: _____

Were child and/or mother hospitalized for medical reasons longer than the usual stay? Yes No

If yes, explain: _____

Has your child been screened by the school district: Yes No If yes, when? _____

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

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

Is your child on an IEP? Yes No (If yes, we will need a copy of the IEP)

Has your child been in counseling? Yes No If yes, are they currently in counseling Yes No

Do you have developmental concerns that are not currently being serviced? Yes No

If yes, explain: _____

Any other concerns: _____

Household Information:

With whom does child reside? _____

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

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:

Does your child take any regular medications? _____

Has child had any serious illness, convulsion, seizure, hospitalizations etc. Yes No

If yes, explain: _____

Has child had any serious accidents (broken bones, head injury, falls, burns, etc.)? Yes No

If yes, explain: _____

Does your child have any allergies? Yes No Allergy: _____
If yes, describe reaction to allergen? _____
Special physical conditions or disabilities (describe)? _____

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

Eating Habits:

Favorite foods: _____ Foods refused: _____
Special diet needs? explain: _____

Are there any foods your child should not eat for any reason? Yes No If yes, explain: _____

Does your child have any eating problems? Yes No If yes, explain: _____

Sleeping Habits:

What time does child go to bed at night? _____ time normally awakes? _____
Does child normally nap? Yes No If yes, how long? _____
What helps your child to fall asleep? _____
What does your child take to bed? _____ mood on awakening? _____
List any sleep concerns: _____

Toilet/Diapering Habits:

Is your child toilet trained? Yes No urination bowels or both
Does your child have accidents? Yes No If yes, how often/when? _____

Does child need any assistance with wiping? Yes No If yes, explain: _____

How many bowel movements are typical during the day? _____ usual time of day? _____

Is there a problem with: diarrhea constipation
Word used for urination: _____ for bowel movement _____
Is child afraid of bathrooms? Yes No If yes, explain: _____

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 your child had previous childcare experience? Yes No If yes, did it meet your needs and expectations? Explain: _____

With other children, is your child normally? friendly aggressive shy withdrawn
Prefers to play: alone in small groups with adult
How does your child show their feelings? _____

Have you had concerns about your child being bullied or bullying? Yes No If yes, explain:

Are there any specific activities and interests your child particularly likes (i.e.: reading, dancing, sports)? _____

Is your child frightened by: animals loud noises dark storms strangers
 other (please list) _____

How do you comfort your child? _____

What methods of behavior control or discipline is used in your home? _____

Do you have any concerns about your child's social development or skills? Yes No
If yes, explain: _____

Partnering With Families:

Is there anything else you can share that will help us know and care for your child? _____

What goals, and/or, concerns do you have for your child? _____

Please describe your child's learning style or approach to learning: _____

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