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 □ bed □ 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