

Background Information

The purpose of securing this information about your child is to help the Center staff better understand your child. Your child's care during the day is a responsibility we share.

Has your child attended any other day care or preschool? If yes, name of school:

Address _____ **How long** _____

Does your child take any medication daily? If yes, please explain _____

Does your child have any food allergies? _____

Does your child have any comforting needs, strong attachments? _____

Types of home discipline most frequently used. _____

Most young children are afraid of some things. Please list any fears, (example: darkness, animals, sirens, being left alone, loud noises, crying, etc.) _____

Please describe your child's favorite activities. _____

Favorite recreational pastime. _____

Does your child have any habits, needs, schedules, or touchy spots you feel we should know about in attempting to personalize our approach? If so, please describe. _____

Child's Developmental History

Does he/she have difficulty speaking? _____

Does he/she use any special words to describe his/her needs? _____

Do you feel your child will adjust easily to the Center? _____

How well does he/she get along with other children? _____

Does your child have any needs requiring special attention? _____

Do you have any special request? _____

We encourage parent participation. If you have any skills or hobbies you would like to share with the children or staff, please let us know. _____

PRESCHOOL CHILDREN QUESTIONS

The following questions only apply to preschool children. If your child is in the after school club house program skip this section of the questionnaire.

Child's Developmental History

Is he/she left handed _____ right handed _____ unknown _____

Has your child had experience with the following:

- | | | |
|--------------|-----------|----------|
| • Clay | Yes _____ | No _____ |
| • Scissors | Yes _____ | No _____ |
| • Painting | Yes _____ | No _____ |
| • Blocks | Yes _____ | No _____ |
| • Water Play | Yes _____ | No _____ |
| • Story Hour | Yes _____ | No _____ |
| • Coloring | Yes _____ | No _____ |

Bathroom Skills

Is your child toilet trained? Yes _____ No _____

If trained, does he/she have accidents? Yes _____ No _____

Does your child wear diapers or pull ups at nap time or at night?

Yes _____ No _____

Child is completely independent? Yes _____ No _____

Child needs reminding when involved? Yes _____ No _____

Child needs assistance with clothes? Yes _____ No _____

What word(s) is used for urination? _____

What word(s) is used for bowel movement? _____

Nap Time

Daily nap? Yes _____ No _____ Sometimes _____

What time does your child go to bed at night? _____

Does your child have any special habits at bed time or nap time? (Sleeping with a special blanket, stuffed animal, etc.) _____

Eating

What is your child's general attitude toward eating? _____

Favorite foods. _____

Least favorite foods. _____

Is your child usually hungry at mealtime? Yes _____ No _____

