

All About Me!

Child's Name _____ Nickname _____

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

How would you describe your child's personality?

Has your child been in child care before? Yes No. If yes, please give last child care 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

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? Yes No. Night Terrors? Yes No. Trouble going to sleep? Yes No. 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? Happy Grouchy Clingy Slow Other _____

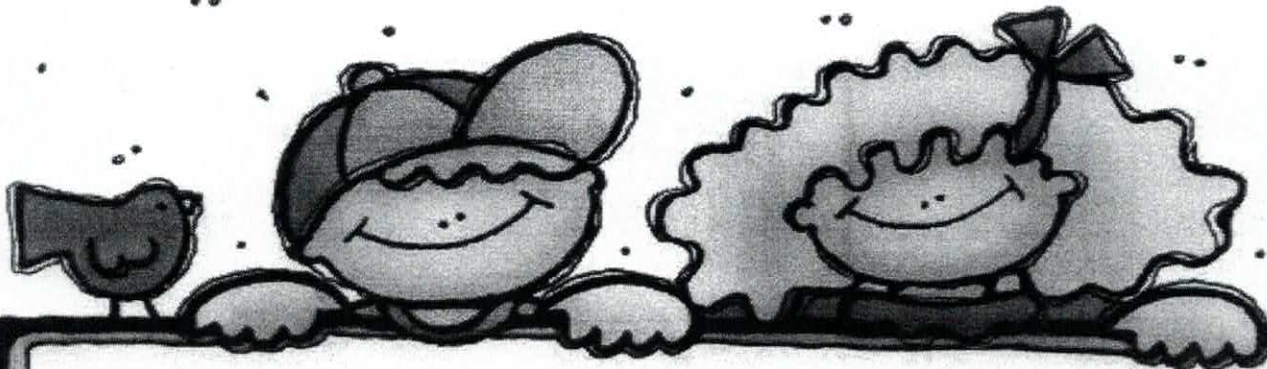
Has or does your child have any known health problems? Yes No. If yes, please describe: _____

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 Ear Aches Headaches Sore Throat
 Other _____

Are there any indications of hearing or vision problems? Yes No. If yes, please describe:

Has your child had any recent illnesses? Yes No. If yes, please describe: _____

Does your child have any physical or mental disabilities? Yes No. If yes, please describe:

Do you have a backup plan if your child is ill and cannot attend daycare, or becomes ill and
must be picked up from daycare? Yes No

What are your child's eating habits (e.g. picky eater, eats anything, time usually eats, etc)?

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

Child's usual dining habits: High Chair Booster Seat Feeds Self Uses Utensils
 Bottle Sippy Cup Regular Cup Other _____

Does your child eat unaided? Yes No. Does he/she enjoy eating? Yes No

Does your child have a special diet? Yes No. 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. If yes, please list foods: _____

Favorite foods: _____

Disliked foods: _____

Where will your child usually eat breakfast? Daycare Home

Is there is anything else special or otherwise you would like us to know about your child?

