Sharon Hill
Daycare · Preschool

Child and Family Information

Child's Name _____

Age_____ DOB_____ Sex_____

1. Personal History

Birth Wt_____ City/State of Birth_____

Name all persons who live in the same household as this child and state relationship.

Name	Relationship
_____	_____
_____	_____
_____	_____
_____	_____

Was this child adopted? Y N NA
Does he/she know? Y N NA
How old was child when adopted? _____

What is the primary language spoken in your child's home? _____

Are there any cultural or religious practices of your family we should be aware of?
(Dietary restrictions, clothing, head coverings, etc.) Y N

If yes, please explain _____
_____
_____
_____

2. Emotional History

Describe your child's nature (shy, talkative, aggressive, etc). _____
_____

What things or events upset your child? (sirens, thunder, animals, etc). _____

_____

How does your child act with strangers or in an unfamiliar setting? _____

_____

Has your child spent much time playing and socializing with other children? If so, explain. (siblings, play groups, previous daycare, etc.) _____

_____

Describe a routine day of your child's. Include time of each activity. Begin with wake-up and end with bedtime. _____

_____

_____

3. Health History

List any known allergies, including food allergies. _____

_____

List all serious injuries and their date. _____

_____

List all hospitalizations and their date. _____

_____

Has your child ever had any speech/hearing/vision problems? (Describe) _____

_____

Has your child ever had problems with any other bodily functions? (Describe) _____

_____

How does your child act when sick? (no appetite, sleeps more than usual, etc) _____

_____

Does he/she run a temperature easily? (100* F or above) Y N

Has your child ever had a convulsion related to a fever? Y N

Is your child on medication now? (Describe) Y N

_____

4. Diet History (circle all that apply)

What does your child eat?
Table food Milk/formula Baby food Baby cereal Juice

What does your child use to eat/drink?
Cup Bottle Cup with lid Spoon Fork Fingers

What type of milk/formula does your child drink?
Breast milk Whole milk 2% 1% Skim Formula (brand) _____

Does your child have problems with:
Spitting up? Constipation? Loose stools? Diaper rash? Colic? Sensitive skin?

If taking a bottle, what kind is used and how often do you burp child? _____

_____

How does teething affect your child? _____

_____

What meals does your child eat?
Breakfast AM Snack Lunch Dinner/Supper PM Snack

What kind of eater is your child?
Eats everything off plate Eats half of food served Eats a few bites

If your child is on a special diet, state reason and explain diet in detail. _____

_____

_____

_____

5. Bowel/Bladder History

Is your child toilet trained? Y N

If not, have you started the toilet training process? Y N

Please explain the process used. _____
_____
_____

What words, gesture, or signs does your child use if he/she needs to use the bathroom?
_____
_____

6. Sleep History

Child's bedtime is _____. Child wakes at _____.

Naps are from _____ to _____.

My child hasn't napped since age _____.

Item(s) my child sleeps with _____.

Mood when waking up is _____.

How is your child put to sleep? (Needs to be rocked, needs music, must be on tummy, needs blanket, etc) _____
_____

Describe child's sleep pattern. (heavy, light, restless, etc) _____
_____

7. Miscellaneous

What discipline techniques work for your _____
_____

What are your expectations of this program? _____
_____

Are there any changes or transitions that your child has recently experienced or is experiencing? (moved from crib to bed, divorce, new home, death of a family member, friend or pet) Additional detail _____
_____