# ALL ABOUT YOUR CHILD

Date _____ Person completing form: _____

Child's Full Name _____ Nickname _____

I have _____ brother(s) and _____ sister(s). Their names and ages are _____

_____

| Others in Family / Household | Relationship | Occupation |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Has your child been in daycare before? Yes_____ No_____

If yes, name of provider or center _____

Provider/Center Address/Phone Number _____

Dates care was provided, from _____ to _____

Reason care was terminated _____

Does your child prefer playing alone? _____ Or with other children? _____

List names of favorite playmates? _____

_____

What is your child's favorite toy? _____

List your child's pets and names of pets: _____

_____

Does your child use the toilet on his/her own? Yes _____ No _____

What skills do you want your child to learn? _____

**Eating Habits:**

Does your child have a special diet? Yes ____ No ____

*If yes, please list the food and the reason _____

_____

Does your child have any food allergies? Yes ____ No ____

*If yes, please list what foods and what kind of reaction (in detail). _____

_____

*(Note that Notation about special dietary form must be on file)

Does your child have any food allergies? Yes ____ No ____

Your child's favorite foods_____

Least favorite foods_____

Does your child eat independently? Yes ____ No ____

**Infants:**

What brand of formula do you use? _____

Baby Cereal: Yes ____ No ____ Rice ____ Oatmeal ____ Mixed ____

If your child is on baby food, number of hours between each mean: _____

Does your child take their bottle immediately after eating food? Yes ____ No ____

If no, how long after eating does your child take his/her bottle? _____

Does your child have any food allergies? Yes ____ No ____

***If yes, please explain in detail what foods and what reaction?_____

_____

_____

**Sleeping Habits:**

_____ No

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

Does your child take naps? Yes _____ No _____

If yes, how long does your child usually nap? _____

Does your child have any problems getting to sleep or staying asleep? Yes _____ No _____

If yes, please explain _____

_____

**Health Concerns:**

Does your child have any known health concerns? Yes _____ No _____

If yes, please describe _____

_____

Does your child take any medications on a regular basis? Yes _____ No _____

If yes, list the medication(s), dosage, and how often taken _____

_____

Are there any hearing or vision problems? Yes _____ No _____

If yes, please describe _____

_____

Does your child have any known allergies? Yes _____ No _____

If yes, please list the allergy and how it is dealt with _____

_____

List any communicable diseases your child has had _____

_____

Does your child suffer from any of the following on a *regular* basis (check all that apply)?

Nosebleeds _____ Headaches _____ Sore throats _____ Stomachaches _____ Runny nose

**Behavior:**

How do you "reward" or "discipline" your child? _____

_____

_____

Anything else about your child that you feel we should know? _____

_____

_____