Help us get to know your child…….

Social Relationships

Has the child had play experience with other children? _____

Has child been in a daycare/preschool setting? ☐ Yes ☐ No Where? _____

By nature is your child: ☐ Friendly/ Outgoing ☐ Active/ Energetic ☐ Passive/ Quiet

Explain:_____

Eating Habits

Child feeds self? ☐ Yes ☐ No Does he/she eat with spoon, fork or hands? _____

General attitude towards eating? _____

Special likes? _____

Dislikes? _____

Dietary Restrictions? _____

Toileting

Trained at _____ months. Does he/she still have occasional accidents? _____

Is your child fully responsible for his/her own toileting? _____

If not, what assistance is needed? _____

How does your child make it known if he/she needs to go to the bathroom? _____

To what degree does your child dress him/herself? _____

Sleeping

Sleeps from _____ to _____ Afternoon nap? _____ How long: _____

What is his/her mood upon awakening? _____

What methods have been useful in helping your child fall asleep? _____

_____

Behavior

Methods parents find most effective in dealing with good behavior? _____

_____

Methods parents find most effective in dealing with misbehavior? _____

_____

Health Information

Please indicate below if your child has had any of the following illnesses or diseases:

Illness	Date/s	Illness	Date/s	Illness	Date/s
Blood Disease		Chicken Pox		Chronic Diseases	
Ear Infections		Convulsions		Diabetes	
Hearing Loss		Emotional		Epilepsy	
Measles		Heart Disease		Kidney Disease	
Glasses		Mumps		Nosebleeds	
Rheumatic Fever		Scarlet Fever		Whooping Cough	

Please indicate any additional illnesses or medical issues below that we need to be aware of:

Condition **Description** **Date/s** **Treatment**

_____

_____

_____

_____

Does your child have any other physical, behavioral, or social difficulties that should be given special consideration?

_____

_____

_____

Allergies: It is important that we are aware of any allergies that your child has. Please indicate below:

Food: _____

Drug: _____

Method of treatment or condition: _____

Health Information Records

Doctor: _____ Date of last physical: _____

Phone: _____ month/ year

Dentist: _____ Date of last exam: _____

Phone: _____ month/ year

Medical Insurance Information

Primary Medical Insurance _____Group _____

Subscriber _____ ID # _____

I have read and verify all the information above.

Parent Signature: _____ Date: _____