About Your Child

MsIrene's SleepyTime Childcare

(Child's name)______________________________________ Date of Birth

Name of Child's School_______________________________Address___________________

Time school starts: ___________________________Time school ends:_________________

1. What FOODS does your child especially like?

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2. Especially DISLIKE?

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3. Favorite toys, games, activities?

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4. Is your child TOILET TRAINED? Yes___ or No___
   If "No" would you like for our staff to begin training your child? Yes___ or No___
   If "Yes" What are the words your child use for toilet? ____________________

5. How does your child express ANGER or frustration?

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6. Does your child have any special FEARS? If so, please explain:

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7. When your child is upset, what helps to COMFORT him/her?

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8. How do you DISCIPLINE your child?

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9. Has your child been taking an afternoon NAP? Yes___ or No___

If so, how long? ______________________What times:__________________

If "NO" explain why?____

10 . Does your child require a special toy or blanket for NAP? Yes___No____

11. Are there any Special FAMILY situations? (*such as custody specifications, problems arising from situations, fostercare placements, etc*.)

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12. List any Anticipated ADJUSTMENT problems?

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14. List any Disorders/Developmental (slow, advanced) diagnosed or suspected?

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Medical/Health History:

Health and medical information is optional. It will be used to better understand your child, provide family resources and meet standards required by state law.

Child's name ________________________________ ___Birth date ______________

Last Physical Examination:

List any Illnesses we should be aware of

Has your child been HOSPITALIZED? (*explain*)

Has your child had INJURIES with fractures or loss of consciousness? (*explain*)

Last VISION Test Date ______________________

Last HEARING Test Date _______________________

Last DENTIST Visit Date ___________________________

Any other members of your family with SERIOUS ILLNESS recently?

Does your child have history of: ASTHMA ________ DIABETES _______ EPILEPSY ______

Does your child have any problems with any …or has your child had any of these diseases?

_____ Constipation Asthma
_____ Convulsions Bronchitis
_____ Diarrhea Chicken Pox
_____ Fainting Spells Diabetes
_____ Frequent Colds Heart Disease
_____ Frequent Ear Infections Hepatitis
_____ Frequent Sore Throats Impetigo

_____ Lice Measles
_____ Ringworm Mumps
_____ Skin Rash German Measles
_____ Soiling Polio
_____ Stomach Upsets Scarlet Fever
_____ Urinary Problem Tuberculosis
_____ Worms Whooping Cough