|  |  |  |  |
| --- | --- | --- | --- |
| **Child Name (last, first, middle)** | **Social Security No.\*** | **Enrollment Date**      | **Date of Birth** |
| **Street Address (if rural, attach directions)** | **City** | **County** | **Zip** |
| **Mailing Address (if different) -- Street or P.O. Box** | **City** | **County** | **Zip** |
| **Telephone No. (include A/C)** |  |  |

\* If applicable.

**1. Health**

|  |  |  |
| --- | --- | --- |
| Does your child have any allergies? | ☐ Yes | ☐ No |
| If so, what allergies does your child have? |       |
| How should we respond if he/she has an allergic reaction? |       |
| Does your child have an existing illness? | ☐ Yes | ☐ No |
| Has your child had a previous serious illness or injury, or hospitalization during the past 12 months? | ☐ Yes | ☐ No |
| Is your child taking any medication? | ☐ Yes | ☐ No |
| If so, how is the medication administered, and will it need to be administered while he/she is in care? |       |
| Is the medication prescribed for continuous use? | ☐ Yes | ☐ No |
| Are there any side effects we should be alerted to? | ☐ Yes | ☐ No |

**2. Toileting:**

|  |  |  |
| --- | --- | --- |
| Does your child need assistance with toileting? | ☐ Yes | ☐ No |
| How can we best help? |       |
| What are your ideas about toilet training? |       |
| How can we best help? |       |

**3. Behavior:**

|  |  |  |
| --- | --- | --- |
| Does your child have any special fears? | ☐ Yes | ☐ No |
| How does your child communicate his/her needs? | ☐ Yes | ☐ No |
| Are there any special words that your child uses that might not be readily recognized? |       |
| How do you tell your child to stop a behavior that you don’t approve of or that might be dangerous? |       |
| When your child gets upset, what helps him/her calm down? |       |
| What is a good way to distract your child when he/she is having a temper tantrum? |       |
| Are there any particular routines that are particularly helpful at naptime? |       |
| What position is most comfortable for your child when he/she is napping? |       |

**4. Eating Preferences:**

|  |  |
| --- | --- |
| What are your child’s favorite foods? |        |
| Does your child use utensils, eat with fingers, feed self? |       |
| Does your child choke easily while eating? | ☐ Yes | ☐ No |

**5. Activities:**

|  |  |
| --- | --- |
| What activities do you like to do with your child? |        |
| What activities does your child like to do when playing with other children? |       |
| What does your child like to do when he is playing alone? |         |

**6. Family History:**

|  |  |
| --- | --- |
| Tell me about your family (i.e. child’s parents, siblings, grandparents, and other extended family) |        |

|  |  |
| --- | --- |
| I verify that the above assessment was discussed with the parent(s) of |       |
|       |
|       |
|  |  |  |
| Signature of Director |  | Date Signed |
| I verify that the director appropriately relayed the information concerning my child’s assessment. |
|  |  |  |
| Signature of Parent |  | Date Signed |

**Additional Comments:**

|  |
| --- |
|        |