|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **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:**

|  |
| --- |
|  |