About Your Child

1. What *FOODS* does your child especially like?____
2. Especially *DISLIKE*? ____
3. Favorite toys, games, activities? ____
4. Is your child TOILET TRAINED? ______ **What words does your child use for toilet?**______________
____
5. How does your child express *ANGER* or frustration?____
____
6. Does your child have any special *FEARS*? ____
Explain ____
7. When your child is upset, what helps to *COMFORT* him/her?__________________________________
____
8. How do you *DISCIPLINE* your child?____
____
9. Has your child been taking an afternoon *NAP*? ___________ **If so, how long?** _____________________
If not, why? ____
____
10 . Special toy or blanket for NAP?____

11. Special FAMILY situations? (such as custody specifications, problems arising from situations, etc.)
____
____
12. Anticipated ADJUSTMENT problems?____
____
13. Any disorders/developmental (slow, advanced) diagnosed or suspected?__________________________
____
14. Previous childcare child has attended:____
____
15. Any problems at previous daycares?____
____

16. EXPECTATIONS of (Your Name) Daycare ____
____
____

17. Other COMMENTS? ____
____
____
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Health History

1. Child's name ______________________________________Birth date:_______________
2. Last Physical Examination:____
3. Food allergies: ____
4. Medicine allergies: ____

5. Illnesses: (please circle)
Does your child have any problems with any of these?

Constipation
Lice
Convulsions
Ringworm
Diarrhea
Skin Rash
Fainting Spells
Soiling
Frequent Colds
Stomach Upsets
Frequent Ear Infections
Urinary Problem
Frequent Sore Throats
Worms

Has your child had any of these diseases?
Asthma
Bronchitis
Chicken Pox
Diabetes
Heart Disease
Hepatitis
Impetigo
Measles
Mumps
German Measles
Polio
Scarlet Fever
Tuberculosis
Whooping Cough

1.Other ILLNESSES? (besides above)
____
2. Has your child been HOSPITALIZED? (explain)
____
3. Has your child had INJURIES with fractures or loss of consciousness? (explain)
____
____
4. Any other members of your family with SERIOUS ILLNESS recently?
____
____
5. Any other members of your family history of: ASTHMA _______ DIABETES ______ EPILEPSY ______

Referral Sources
(Please circle all that applies)
Advertisement Referral
Drive-by Sign Parental Referral
Center Referral
Newspaper Referral
Dept. Human Resources