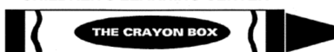
Parent's Report

CHILDREN'S LEARNING CENTER



ANDREWS UNIVERSITY

Child's Name: __________________________________ Date of Birth: _______________

Family

1. Does the child's father live in the same home as the child? Yes____ No____
2. Does the child's mother live in the same home as the child? Yes____ No____
3. Does the child have any siblings? If so, what ages?
   ____
4. Do other family members or friends live at home with the child? If so, who?
   ____

Feeding

(Infant Room)

5. Is your child _____ breast fed or _____ formula fed?
6. Are you aware of any allergies? ____
7. What is your child's typical daily eating pattern? Please include approximate time and typical food.
   Morning:____
   ____
   Afternoon:____
   ____

(Toddler room and up)

8. Are there any foods your child is allergic to? _________________________________
9. Are there any foods your child will not eat? __________________________________
10. Does your child drink from a cup? Yes____ No____
11. Does your child use silverware? Yes____ No____
12. What is your child's typical daily eating pattern? Please include approximate time and typical food.
    Breakfast:____
    Lunch:____
    Afternoon Snack:____

Sleeping

13. Does your child sleep during the day? Yes____ No____
    If yes, when? _________ to _________
    _________ to _________
14. Do you have any special ways of helping your child fall asleep? _____________
    ____
15. Does your child need a special blanket or toy to fall asleep? ________________
    ____

Toilet Habits
(*Toddlers and up*)

16. Is your child trained to use the toilet without adult help? Yes____ No____
17. Is your child in the process of being toilet trained? Yes____ No____
    If yes, please explain. ____
    ____
18. What words or actions does your child use when he/she needs to use the toilet?
    ____
    ____

Developmental History

19. At what age did the child begin to crawl? ____________
20. At what age did the child begin walk? _______________
21. At what age did the child begin to talk? ______________
22. Has the child had group care experience? Yes____ No____
23. Please describe how your child acts in a group play situation.
    (Check all that apply)
    - Nervous, worried
    - Hyper, restless, can't sit still
    - Pushy, bullies others
    - Relaxed, calm
    - Social, friendly
    - Shy, withdrawn, keeps to self
    - Gets angry easily
    - Scared, fearful

24. Does the child have any special problems or fears? _________________________
    ____
25. What are you child's favorite activities or toys? ______________________________
    ____
26. How do you discipline your child? _______________________________________
    ____
27. How do you comfort your child? ____
    ____

Other
(*Is there anything else we should be aware of?*)
____
____
____
____

Signature ____________________________________ Date ____________________