Parent’s Report

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)
   o Nervous, worried
   o Hyper, restless, can’t sit still
   o Pushy, bullies others
   o Relaxed, calm
   o Social, friendly
   o Shy, withdrawn, keeps to self
   o Gets angry easily
   o 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 ____________________