



# INFANT / TODDLER

## “ALL ABOUT ME” FORM

Child’s Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

What would you like us to call your child? \_\_\_\_\_

### DEVELOPMENTAL HISTORY

Age child began sitting: \_\_\_\_\_ crawling \_\_\_\_\_ walking \_\_\_\_\_ talking \_\_\_\_\_

Does child:  pull up  crawl  walk with support

Times child is fussy: \_\_\_\_\_

How do you handle these fussy times? \_\_\_\_\_

### FAMILY INFORMATION

With whom does child reside? \_\_\_\_\_

Who else lives in the home (siblings, extended family, pets)? \_\_\_\_\_

What does child call family members? \_\_\_\_\_

Language spoken at home: \_\_\_\_\_

Are books read in languages other than English? \_\_\_\_\_

Are there words in your home language that we should know? \_\_\_\_\_

Please tell us about any cultural family customs, rituals or traditions that will help us make your child’s experience more meaningful:

### HEALTH/ DEVELOPMENT

Serious illnesses or hospitalizations (describe)?

Any history of colic?

Special physical conditions, disabilities, or allergies (describe)?

Is your child presently or ever been diagnosed with a special need? \_\_\_\_\_

If so, is he/she receiving any special services? \_\_\_\_\_

Regular medications? \_\_\_\_\_

### EATING HABITS

Special characteristics or difficulties? \_\_\_\_\_

Special diet: \_\_\_\_\_ Formula: \_\_\_\_\_ Breast Milk: \_\_\_\_\_

How often \_\_\_\_\_

Any food allergies? \_\_\_\_\_

Have solid foods been introduced? YES NO

If yes, please identify: \_\_\_\_\_

Favorite foods: \_\_\_\_\_ Foods refused: \_\_\_\_\_

Child eats: on lap in high chair other

Child eats with: spoon fork hands other

### TOILETING/DIAPERING HABITS

Is there frequent diaper rash? YES NO

Do you use: cream powder lotion other : \_\_\_\_\_

Are bowel movements: regular YES NO how often: \_\_\_\_\_

Is there a problem with: diarrhea YES NO constipation YES NO

Is your child toilet trained: YES NO If yes, when did you begin? \_\_\_\_\_

Any issues with urination: YES NO bowels: YES NO Explain: \_\_\_\_\_

What is used at home: potty-chair special seat regular seat

Word used for urination: \_\_\_\_\_ bowel movement: \_\_\_\_\_

Does your child have accidents? yes no If yes, how often/when? \_\_\_\_\_

### SLEEPING HABITS

Does child sleep in: crib bed with parents

Does child sleep on: back side stomach

(At center we must use "Back to sleep in accordance with our licensing policies)

Times child take naps? Times: a.m. \_\_\_\_\_ - \_\_\_\_\_ p.m. \_\_\_\_\_ - \_\_\_\_\_

Additional napping information? \_\_\_\_\_

What does child take to bed? \_\_\_\_\_ mood on awakening: \_\_\_\_\_

What time does child go to bed at night: \_\_\_\_\_ awake in morning: \_\_\_\_\_

Are there any sleep/wake time rituals? If so, please describe:

\_\_\_\_\_

### **SOCIAL RELATIONSHIPS**

Has child had any experience playing with children? If so, please describe.

Is child:        friendly    aggressive    shy        withdrawn

Reaction to strangers? \_\_\_\_\_

Have you had any previous child care experience?    yes    no

If yes, did it meet your needs and expectations? Explain: \_\_\_\_\_

\_\_\_\_\_

Prefers to play:        alone                in small groups

Favorite toys and activities? \_\_\_\_\_

Is child frightened by:    animals                rough children                loud noises                dark                other

Explain: \_\_\_\_\_

How do you comfort your child? \_\_\_\_\_

How does your child prefer to be held? \_\_\_\_\_

### **DAILY SCHEDULE**

Please describe by approximate time your child's current daily activities (e.g., awakening, eating, time out of crib, napping, toilet habits, fussy time, bedtime):

### **PARENTING PHILOSOPHY**

Do you have ideas about parenting that would help us to better care for your child as an individual?

What do you, as a family, hope to get out of this child care experience?

\_\_\_\_\_

(Parent's/Guardian's Signature)

\_\_\_\_\_

(Date)

\_\_\_\_\_

(Parent's/Guardian's Signature)

\_\_\_\_\_

(Date)