

Toileting Patterns

Is your child fully potty trained? _____ if not fully, please describe _____

How would you describe your child's urination/bowel movements? _____

Eating Patterns

What does your child eat for breakfast? _____

Lunch? _____ Dinner? _____

Does your child use a Bottle? _____ Sippy Cup? _____ Cup? _____ Spoon? _____ Fork? _____

What are your child's favorite foods? _____

What are your child's least liked foods? _____

Are there any foods that are restricted for religious or other reasons? _____ If yes Center will provide substitutions. Please list restricted foods. _____

Health Issues

Are there any concerns about growth/development that may become apparent at childcare? _____

If yes please explain. _____

Does your child suffer from recurring illness? _____

Does your child take any medication regularly? _____

Are there any limitations to your child's play or movement? _____

Does your child have any allergies to medications, substances etc.? _____

If yes, please list (Doctor documentation required) _____

Does your child have any food allergies? _____ If yes please list (Doctor documentation required).

General Information

What are your child's favorite indoor and outdoor activities? _____

Does your child have any specific fears? _____ If yes, please explain _____

What does your child do when angry or frustrated? _____

What forms of behavior modification/discipline are used in your home? _____

Please list anything else you would like us to know about your child _____
