



Kids Edu Caring Place - 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 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 at table other

Child eats with: spoon fork hands other

TOILETING/DIAPERING HABITS Is there frequent diaper rash? YES NO

Do you use: cream powder lotion medication other: _____

Are bowel movements: Regular YES NO how often: _____



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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 (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

Where: _____ If yes, did it meet your childcare 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) _____