About Your Child

1. What FOODS does your child especially like? ____

2. Especially DISLIKE? ____

3. Favorite toys, games, activities? ____

4. Is your child TOILET TRAINED? ______ What words does your child use for toilet? ________________

5. How does your child express ANGER or frustration? ____

6. Does your child have any special FEARS? ____

Explain ____

7. When your child is upset, what helps to COMFORT him/her? ______________________________________

8. How do you DISCIPLINE your child? ____

9. Has your child been taking an afternoon NAP? ___________ If so, how long? ________________

If not, why? ____

10 . Special toy or blanket for NAP? ____

11. Special FAMILY situations? (*such as custody specifications, problems arising from situations, etc.*)____

____

12. Anticipated ADJUSTMENT problems? ____

____

13. Any disorders/developmental (slow, advanced) diagnosed or suspected? ________________

____

14. Previous childcare child has attended: ____

15. Any problems at previous daycares? ____

16. EXPECTATIONS of Day Care Home ____

____

17. Other COMMENTS? ____

____

<u>Health History</u>

1. Child's name ____________________________________BirthDate _____________
2. Last Physical Examination ____

3. Illnesses: (*please circle*)

Does your child have any problems with any of these?	Has your child had any of these diseases?
Constipation	Asthma
Convulsions	Bronchitis
Diarrhea	Chicken Pox
Fainting Spells	Diabetes
Frequent Colds	Heart Disease
Frequent Ear Infections	Hepatitis
Frequent Sore Throats	Impetigo
Lice	Measles
Ringworm	Mumps
Skin Rash	German Measles
Soiling	Polio
Stomach Upsets	Scarlet Fever
Urinary Problem	Tuberculosis
Worms	Whooping Cough

3. Other ILLNESSES? (*besides above*) ____
4. Has your child been HOSPITALIZED? (*explain*) ____
5. Has your child had INJURIES with fractures or loss of consciousness? (*explain*)
   ____
   ____
6. Last VISION Test Date ___________________Last HEARING Test Date _________
7. Last DENTIST Visit Date ___________________________
8. Any other members of your family with SERIOUS ILLNESS recently?____
   ____
9. Any other members of your family history of: ASTHMA ____DIABETES ____ EPILEPSY____