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**PRESCHOOL CHILD DATA INFORMATION**

|  |  |  |
| --- | --- | --- |
| Child’s Name:       | D.O.B:   \  \     | Today’s Date:   \  \     |

**Dietary & Medical Information**

|  |
| --- |
| Please list any allergies and\or dietary restrictions your child has:      |
| Does your child require an Epi-Pen to treat a reaction to any allergies?  |
| Do you do anything for teething?  |
| Is your child on regular medication? If so please list.  |
| Does your child eat by him\herself? |  | Explain:            |
| Do you have any concerns about your child’s eating habits? |  | Explain:            |
| How would you describe your Child’s Appetite |  | Explain:            |
| When does your child eat best (Check all that apply) | Breakfast [ ]  | Lunch [ ]  | Dinner [ ]  | Snack [ ]  |
| **Please list some of your child’s dietary likes and dislikes:** |
| Likes:      |
| Dislikes:      |

**Daily Routine Information**

|  |
| --- |
| Briefly describe an ordinary day in the life of your child, from his]\her wake up until bedtime      |
| Does your child sleep well? |  | Explain:      |
| Does your child usually nap: |  | Explain: (please include typical times and duration of naps)      |
| Do you have any concerns about your child’s sleeping habits? |  | Explain:      |
| Nap \ Rest Times:      |
| What does the child take to bed (blanket, pillow, toy, etc….)      |
| Describe how your child is typically put down for a nap\bedtime:      |
| Does your child typically sleep alone? (Explain)      |
| Child typically sleeps in: |  |

**Toilet Habits**

|  |  |  |
| --- | --- | --- |
| Is your child toilet trained for: | Urine | Bowels |
| Yes [ ]  | No [ ]  | Yes [ ]  | No [ ]  |
| How frequently do accidents occur & what time of day do they usually happen?      |
| Is diarrhea or constipation a problem? (If so how do you treat it)      |
| Do you have any concerns about your child’s toileting habits? If yes please describe:      |

**Miscellaneous Information**

|  |
| --- |
| Has your child had any previous school or play group experience?      |
| How do you anticipate your child will adjust to this child care program?      |
| How does your child relate to strangers?      |
| Please describe any particular habits, fears, or mannerisms your child displays.      |
| Does your child have words\nicknames for things and\or caregivers we might not be able to understand or figure out?       |
| **What are your Child’s Favorite…..** |
| Toys | Books | People |
|       |       |       |
|       |       |       |
|       |       |       |

**Developmental History**

|  |
| --- |
| Were there any pregnancy or birth difficulties with this child? If yes, please describe      |
| At what age did your child: | Sit Up | Crawl | Walk Unsupported | Talk in short phrases |
|       |       |       |       |
| Do you have any concerns with your child’s development:      |
| Did\Does your child receive support services (OT, PT, Speech\language). If so please describe.      |

**Family Information**

|  |
| --- |
| Who does your child live with? (Please include people in the household, living arrangements and custody agreements. If the child alternates between households, please explain)      |
| Have there been any difficulties or crises in your family such as divorce, death, legal issues or medical problems that may have emotionally affected your child? If yes, please describe:      |

|  |
| --- |
| Please include any other information you would like us to know about your child:      |

**Approximate Drop off \Pick up times & Person**

(We do understand that this can change, but having estimated times will help us to plan our day and will be helpful in assigning your child’s primary caregivers)

|  |  |  |
| --- | --- | --- |
|  | Drop Off | Pick Up |
|  | Time | Person | Time | Person |
| Monday |      a.m. |       |      p.m. |       |
| Tuesday |      a.m. |       |      p.m. |       |
| Wednesday |      a.m. |       |      p.m. |       |
| Thursday |      a.m. |       |      p.m. |       |
| Friday |      a.m. |       |      p.m. |       |