Getting to Know Your Child

(Infant/Toddler)

Please complete this form so that we may get to know your child better.

Child's Name _____ Birth Date _____

Nickname/What would you like us to call your child? _____

Health

Any allergies? _____

Any medical conditions? _____

Is your child teething? Special instructions when teething _____

Large Motor Skills

Age learned to roll over _____ to sit up _____ to crawl _____ to stand _____ to walk _____

Small Motor Skills

Age learned to hold objects _____ to transfer objects hand to hand _____ to hold a cup _____

Age began self feeding _____

Social Relationships

Previous group/babysitting experience _____

Favorite toys and activities at home _____

Is your child generally happy _____ shy _____ trusting of others _____ other _____

Does he or she have siblings? _____ What age? _____

Eating

Favorite foods _____

Food dislikes _____

Food allergies/restrictions _____

Has your child started eating: Solid Food _____ Cereal _____ Fruits _____ Vegetables _____ Meat _____
Table Food _____ 2% Milk _____

Sleeping

Naps: How many naps a day does your child take? _____ Approximately what times? _____

How does your child like to fall asleep? _____

What is the preferred sleeping position? _____

More information regarding your child's eating and sleeping schedule/Additional Comments:

_____

_____

_____

_____

Thank you!