bright futures
learning center

INFANT/TODDLER "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 with support

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 ☐ other

Child eats with: ☐ spoon ☐ fork ☐ hands ☐ other

TOILETING/DIAPERING HABITS

Is there frequent diaper rash? ☐ yes ☐ no

Do you use: ☐ oil ☐ powder ☐ lotion ☐ other

Are bowel movements: ☐ regular how often: _____

Is there a problem with: ☐ diarrhea ☐ constipation

Is your child toilet trained: ☐ yes ☐ no If yes, when did you begin? _____

☐ urination ☐ bowels or ☐ both

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

Does child sleep on: ☐ back ☐ side ☐ stomach

(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

If yes, did it meet your 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? _____

What is your style of disciplining? _____

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)