It is our intention at Play and Learn to foster a strong reciprocal relationship with the families that we serve. The purpose of the following form is to help us get to know your child and your family better so that we may serve your family better. If there are any questions that you do not feel comfortable answering, you may leave it blank. This form will be kept strictly confidential. Only your child's teacher and administration will have access to the information contained in this form.

Child's name: _____DOB: _____

Parent's name: _____ Date: _____

Feeding Plan:

Liquids-

Child is to be fed the following:
□ Breast Milk
□ Formula- Brand _____
□ Milk- Special _____
□ Juice

Child now uses:
□ Bottle _____
□ Cup _____
□ Spoon _____
□ Fork _____

Solid Foods-

Child is currently on solid foods? □ Yes □ No
Child can feed self? □ Yes □ No
What age (if not currently) did you begin to introduce solid foods? _____

Feeding Schedule-

How many ounces or cups per day? _____
Breast Milk _____ Formula _____ Milk _____ Juices_____
Approximately what time do you usually offer your child solid foods? _____
What time of day do you want us to offer solid foods? _____

Food Allergies:

Allergy special instructions:
_____
_____

Special instructions from child's pediatrician relating to nutrition:

_____
_____
_____

Sleeping Patterns:
Sleeping Schedule-

Does your child take a nap in the morning? ▫ Yes ▫ No
Approximately what time? _____ Usually how long? _____
Does your child take a nap in the afternoon? ▫ Yes ▫ No
Approximately what time? _____ Usually how long? _____
Does your child sleep with any transitional objects (blankets, pacifier, etc.)? ▫ Yes ▫ No
If yes, what objects? _____
Special instructions: _____
_____

Does your child fall asleep easily? _____ Yes ____No

Does your child have difficulty staying asleep? ____Yes ____No

Please describe your child's mood upon
awakening:_____

Diapering and Toilet Training Plan:

Diaper/Toilet Training-

Infants and toddlers will be checked frequently and will be kept clean and dry. Child uses:
▫ Disposable diapers- Brand _____
▫ Wipes- Brand _____
▫ Training Pants- Brand _____
▫ Potty chair
▫ Toilet

Does your child have highly sensitive skin? _____ Yes ____ No

Does your child get frequent diaper rash? ____Yes ____ No

Does your child use any lotion, powders or ointments? ___ Yes ____ No
If yes, please specify type and brand:
_____

Special instructions from child's pediatrician relating to diapering/toileting:
_____
_____
_____

Individual Schedule of the Infant/Toddler Routine:

Arrival Time: _____ Pick up Time: _____
Morning Feedings: _____ Morning Nap: _____
Mid day Feedings: _____ Mid day Nap: _____
Evening Feedings: _____

Active play, diapering and toileting and all other interactions will be provided around your child's routine.

How would you describe your child's personality?
_____

Does your child have a fussy time? ____ Yes ____ No
If yes, please specify time:
_____
If yes, how is fussy time handled?
_____
Does your child have any fears?
_____

What are your child's interests?
_____

Was your child born full term? _____ Yes _____ No

Is your child able to do any of the following? If so at what age did he/she begin?
Sit up alone: _____
Pull up: _____
Crawl: _____
Walk holding on: _____
Walk with support: ____

Please describe any challenging or unusual behaviors that we should be aware of as well as any family customs, traditions, religion or nationality that these behaviors may be linked to?
_____
_____
_____
_____
____

Does your child have frequent colds, ear infections, colic, etc.? _____ Yes _____ No
Please describe if yes:
_____

Do you have any concerns about your child's development? ____ Yes ____ No

Is your child on any daily medications? _____Yes _____No
If yes, are there any side effects that we should be aware of?_____

Is this your child's first experience with a group of children? ____Yes ____No

Does your child have any special needs? ___Yes ____No
If yes, is this special need _____Medical or _____ Developmental? (check one)
If Medical, has the child been diagnosed by a physician ____yes ____no
If yes, what is the diagnosis: _____
If Developmental, has the child been evaluated by birth to three?
___yes _____no
If yes, what was the result of the evaluation: _____

About Your Family

What language is spoken at home? _____

Does anyone outside of your home, that your child is close with, speak another language. If so, what language?
_____

Please tell us about some of the special people in your child's life (grandparents, aunts, uncles, etc.) what their relationship to your child is and what your child calls them:

_____

_____

Please list any pets that live in your home and their names:

_____

What is your family's ethnicity? _____ Religion? _____

Please list the holiday's that your family celebrates:

_____

_____

Please list any holiday's that your family does not celebrate:

_____

_____

Do you have any unique holiday traditions in your family? __Yes __No

Would you be willing to come in and share with our children any of your family's traditions, holidays or cultures? __Yes __No

Is there anything else that you would like to share with us?

_____

_____

_____

_____

Please share your feelings and expectations regarding your child's care and education.

_____

_____

_____

_____

_____

_____

This form is required to be updated four times per year as your child's needs change and reviewed with parent/guardian prior to being signed and approved by persons listed below.

Parent/Guardian's Signature Date

Teacher's Signature Date