Hundred Acre Play Care

CHILD INFORMATION

CHILD INFORMATION

Child's Name (Last, First, MI) and Nickname

Birthdate (mm/dd/yyyy)

Primary Home Address

First Day of Attendance

PARENT OR GUARDIANS

Parent/Guardian Name

Relationship to Child

Occupation

Home/Cell Phone Number

Email

Child Calls the Parent/Guardian:

Parent/Guardian Name

Relationship to Child

Occupation

Home/Cell Phone Number

Email

Child Calls the Parent/Guardian:

Adults in the home are: (Please circle all that apply)

Married
Separated
Widow/Widower
Father Only
Mother Only

Divorced
Joint Custody
Not Married
Extended Family
Other:______________________

Other Household Members:
Name, Age, Relationship- Don't forget the pets!

CULTURAL BACKGROUND

Primary language spoken at home:

Other language(s) your child is exposed to:

Are there any cultural practices/holidays followed in your home you would like to share with us?

Is there anything else you would like us to know about your religion and/or culture?

HEALTH HISTORY

Does your child have a history of:
___allergies
___asthma
___ colic
___ colds
___compromised immune system
___constipation
___delays in development (including verbal)
___diabetes
___ ear infections
___heart problems
___motion sickness
___nose bleeds
___seizures
___sensory sensitivities
___any other condition not listed

Please discuss any physical condition, allergy (food, drug, enviornmental), serious illness, health consideration, or developmental delay that your child has or had that could affect their school experience:

Are any medications given to your child regularly? YES NO
If yes, please list/explain:

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SOCIAL AND EMOTIONAL DEVELOPMENT

Is your child used to other playmates? What experiences has your child had with peers/other children?

Who is your child cared for outside of their time at HAPC?

How does your child respond to interactions with other children?

Does your child engage in play with peers? YES BEGINNING NOT YET

What activities/toys does your child enjoy? (indoors and outdoors)

Does your child play independently? If so, what types of activities?

What are some of your child's strengths?

What, if any, are your concerns about your child?

Please describe your family's child guidance techniques.

Does your child have a comfort item or favorite toy? (stuffed animal, blanket, pacifier, bottle, etc) When do they use it at home?

Does your child have a "fussy time"? When? How is it handled?

Ways your child enjoys to be comforted/soothed: HOLD SING ROCK READ TALK SPECIAL ITEM OTHER:

Are there any special circumstances in your family that we should know about? (divorce, birth of a sibling, moving, hospitalization, death, etc)

COMMUNICATION AND PHYSICAL DEVELOPMENT

Does your child have any special physical needs?

Child can (circle all that apply):

ROLL OVER SIT UP ALONE PULL UP CRAWL WALK HOLDING ON WALK ALONE RUN SKIP JUMP HOP

What is your child's hand preference? RIGHT LEFT UNSURE

How does your child express feelings of happiness and enjoyment?

What causes your child to feel angry, frustrated, or frightened? How do they show this?

How does your child communicate their needs? (crying, specific cues, gestures/sign language, special sounds, words, etc.)

Age child began using words/talking? If not talking yet, skip to next section.

If your child uses words to communicate, please give an example of a phrase or sentences they are currently using.

Words used for specific needs:
FOOD:

SLEEP:

BATHROOM/DIAPER:

COMFORT:

OTHER:

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CHILD INFORMATION

SLEEP AND REST:

Where does your child sleep? (Co-sleep, crib, bed, on the go, etc)
NIGHT: NAPS:

Child's favorite sleep position (over 1 year): BACK SIDE/STOMACH

Child's favorite sleep position (under 1 year): BACK SIDE/STOMACH WITH NOTE*
*Children under 1 year must be put to sleep on their back until they can roll unassisted unless a statement from their pediatrician is on file.

What time does your child usually go to bed at night and wake in the morning?

When does your child nap at home and for how long?

Do you/they follow a regular sleep schedule? YES NO SOMETIMES

How long has your child been in their current sleep/nap pattern?

What does your nap/bedtime routine look like at home?

Does your child fall asleep easily? YES NO Does your child fall asleep on their own? YES NO

Does your child sleep with a comfort item? (over 1 year only)

What is your child's usual mood upon waking?

MEALS & EATING

What is your child's current eating/feeding schedule? How long have they had that schedule?

Current food type: FORMULA BREAST MILK BABY FOODS TABLE FOODS

Type of milk: Whole 1% 2% NONE OTHER:

Child eats in: LAP/HELD HIGHCHAIR BOOSTER SEAT CHAIR OTHER:

Does your child eat independently? YES NO

Does your child use eating utensils? YES NO Circle those that apply: SPOON FORK HANDS OTHER:

What type of cup does your child currently use? BOTTLE SIPPY CUP STRAW CUP OPEN CUP

What are some of your child's favorite foods?

Refused foods?

Any food issues or feeding problems that would be helpful for us to know?

Are there any foods your child CANNOT eat or do they have any allergies to food?

Does your family have any special eating rules or rituals?

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CHILD INFORMATION

DIAPERING & TOILETING

Diaper Type: DISPOSABLE CLOTH PULL UP UNDERWEAR

Does your child have sensitive skin? YES NO

Does your child have frequent diaper rash? YES NO

Do you use lotions, powders, or diaper creams? NO YES- specify:

Does your child have regular bowel movements? YES NO OTHER How often/ time of day?

What words do you use for urination and bowel movements at home?

Does your child have any other toileting problems, challenges, or things we should know?

Is your child interested in sitting on the toilet? YES NO- if no, skip this section

Is your child toilet trained or toilet training at home? YES NO

Type of toilet used at home: POTTY CHAIR SPECIAL /CHILD SIZE SEAT REGULAR TOILET SEAT OTHER:

Do they need reminders or prompting to use the toilet? YES NO

Can your child use the toilet, manage clothing, and wash hands independently at home? YES NO SOMETIMES

Can your child communicate a need to use the bathroom before going? YES NO SOMETIMES

GOALS

What are your goals for your child while attending Hundred Acre Play Care?

MISCELLANEOUS:

Is there anything else you would like to share with us at this time to help make a smooth transition for your child?

SIGNATURE- Parent/Guardian

DATE

REVIEW DATES: