First United Methodist Child Care Center

All About Me

You can help us plan for your child's needs, understand concerns, support & encourage your child by providing the following information. This information will remain confidential.

Child's Full Name _____ Nickname _____Date of Birth _____

Mother/Guardian Name _____Father/Guardian Name _____

Marital Status: Married, living together _____ Separated _____ Divorced _____ Single _____

If divorced, please describe custody and visitation agreement for the child

_____

_____

I have ____ brothers & ____ sisters, their names and ages are: _____

_____

Other significant persons in your child's life (stepfamilies, grandparents, baby-sitters & so forth). Please note relationship to child. _____

_____

How would you describe your child's personality? _____

_____

What opportunities does your child have to play with other children? _____

_____

What are your child's favorite play activities? _____

Do you consider your child hard or easy to manage? _____

What methods of discipline have you found most effective? _____

What fears does your child have? _____How are they expressed? _____

Has your child been in childcare before? ( ) yes ( ) no If yes, please give last childcare provider, or daycare center's information:
Name: _____

Does your child have a regular bedtime schedule? ( ) yes ( ) no What time does your child usually go to bed at night? _____ What time does your child usually wake up in the morning? _____ Does your child have trouble sleeping? _____ Night Terrors? ____ Trouble going to sleep? _____ Other: _____

Does your child nap regularly? _____ What time(s) and for how long does your child usually nap? _____
_____

If infant, how does your child sleep? Stomach _____ side _____ back _____

Are there any special dolls, blankets, etc. that your child needs to go to sleep? _____

What is your child's disposition upon waking up? happy, grouchy, clingy, etc _____

Please continue on back side of form

Has or does your child have any known health problems? ( ) yes ( ) no If yes, describe: _____

Does your child need regular medication? ( ) yes ( ) no If yes, what and when is it given? _____

Does your child have any known allergies? ( ) yes ( ) no If yes, please list allergens: _____

Special instructions in case of an allergic reaction: _____

_____

Has your child had any of the following communicable diseases? chicken pox, measles, mumps, other _____
_____

Is your child prone to upset stomach, colds, seasonal allergies, ear infections, headaches, sore throats, nose bleeds, other _____

Are there any indications of hearing or vision problems? _____

Has your child had any recent illnesses? ( ) yes ( ) no If yes, describe: _____

Does your child have any physical or mental disabilities? ( ) yes ( ) no If yes, explain: _____

What are your child's eating habits? (mind trying new things, times usually eats, etc.) _____

If infant, breast milk _____ formula_____ kind of formula _____

Child's usual dining habits: (circle all that apply) high chair, booster seat, feeds self, uses utensils, bottle, sipper cup regular cup, eats unaided, enjoys eating

Does your child have a special diet? _____ Due to your child's tastes, allergies, reactions, and/or religious beliefs, are there any foods that should not be served to your child? ( ) yes ( ) no

Please list these foods: _____
Favorite foods: _____
Strong dislikes: _____
Will your child usually eat breakfast here or at home? _____

What are your expectations of this program?
_____
_____
_____
_____
_____