Getting to Know Your Baby

Your child is very important to us and we would like you to help us get to know him/her better. The following information will assist us in providing the best care for your child. Please complete this form and return it to the office.

Development History:
Child's Name____Birthdate_______________________________________
Address____Phone____

Health:
Any Allergies? ____
Frequent Colds? ___________________________Frequent Stomach Aches?_____________________________________
Special instructions if your child becomes ill ____
____
____

Social Relationships:
Previous group experience____
By nature, is child: friendly_______________aggressive________________shy_______________withdrawn_____________
Does he/she have any siblings? ____
Knows the following children in our school:____
Favorite toys and activities at home____
____

Comments:
In what particular way can we help your child this year? What do you hope your child will gain from this experience?
____
____
____

Eating:
Average spand between bottles?______hours. Drinks approximately______ozs.
Any snacks between meals?____
On table food ______________________Baby food______________________What stage?___________________________
Favorite Foods ____
Food Dislikes ____
Food Allergies ____

Sleeping:
Time child goes to bed in P.M.? ___________ Awakens in A.M.? ______________
Does child have own room?______ Mood when awakened____________________
Average time and duration of naps A.M.________________P.M.________________
Sleeps on back? Stomach? Side?____

Additional comments or information: ____
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