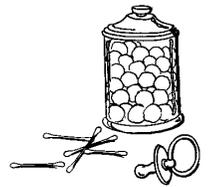


Storyland Infant/Toddler Child Information Form



Child's Name _____ Nick Name _____ Age _____

Birthday _____ Scheduled days to attend _____

Mother's Name _____ Father's name _____

Name and Age of siblings _____

Names of people in the home where child resides _____

Has your child been cared for by anyone other than parents? _____

Has your child previously attended a day care center, in home day care, Head Start, or relative care? _____ If so, where and where _____

Family Traditions and Information: Infants & Toddlers

Special holidays or family traditions that your family celebrates? _____

Special customs that we should be aware of? (cultural, ethnic, etc.) _____

Favorite things that the family does together (hobbies, outings, activities) _____

Major language spoken in the home _____

Religious Preferences _____

History: Infants & Toddlers

Has your child ever been hospitalized? _____ For what? _____

Does your child have any known allergies? (food or otherwise?) _____

Has your child had any previous serious illnesses or injuries? _____

Does your take any medications for long-term conditions? _____

Does your doctor have any concerns about health, development, or behavior issues? _____

Do you have any concerns about health, development or behavior issues? _____

If so, would you be interested in a referral to ECI? _____

Eating Habits: Infants (Please complete infant feeding schedule)

Eating Habits: Fill out for Toddlers 12 months through 3 years old only

1. At what time does your child normally eat meals & snacks? _____

2. Does your child drink from a sippy cup? YES NO

3. Child drinks: whole milk 2% milk Skim milk Formula Breast milk Other

4. Does your child have any favorite foods? _____

5. Does your child have any food dislikes _____

6. Food allergies _____

7. Is your child on a special or modified diet? _____ If so, please explain _____

What else would you like us to know about your child's eating habits?

Sleeping Habits: Fill out for Infants & Toddlers

1. At night, child sleeps from _____ to _____.

2. Normal bedtime routine:

3. Does your child nap? _____ From _____ to _____ and _____ to _____

4. Special comfort methods, or objects that help put child to sleep if any

5. Is there anything special we need to know about sleeping routine?

Toilet Habits: Fill out for Toddlers only

1. Is your child fully potty trained?

2. Has your child shown interest in the potty?

3. Are you actively potty training?

4. Is there anything special we need to know about toileting habits?

Skills: Fill out for Infants only

1 YES NO Does your baby turn over from tummy to back?

2 YES NO Does your baby turn over from back to tummy?

3 YES NO Can your baby crawl?

4 YES NO Can your baby sit up by self?

5 YES NO Can your baby sit up with support?

6 YES NO Can your baby pull self up to standing position?

7 YES NO Can your baby stand unassisted?

8 YES NO Is your baby walking ?

9 YES NO Does your child take a pacifier? When

Activities: Fill out for Toddlers only

1. Favorite toys, playthings:

2. Any favorite activities:

3. Any fears

4. Any particular skills that your child is working on at this time?

5. Special words unique to your child that we should be aware of?

6. What are your normal methods for responding to his/her negative behaviors?

7. What are your thoughts about child rearing?

Fill out for Infants and Toddlers

Is there anything else you think we should know about your child? Please use additional sheets of paper if necessary.

How can we best serve your child and your family?

Volunteer Information

Would you be interested in participating in the following activities if they were offered?

Parenting Classes	YES	NO
Parent Advisory Board	YES	NO
Classroom Volunteer	YES	NO
Parent/Teacher Conferences	YES	NO
Share a hobby, occupation, family tradition, cultural experience	YES	NO