



Child's Name: _____

Does your child have a nickname? Yes No If Yes, what is it? _____

Family

Names of brothers and sisters (include nicknames)	Birth dates	Does this sibling live in the same home as this child?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Names of others living in the home	Relationship to child
_____	_____
_____	_____
_____	_____

What languages are spoken in your home? _____

Does your child have any pets? Yes No If Yes, what are they? _____

Food

Is your child **breast-fed**? Yes No

If **Yes**:

Do you plan to continue breast-feeding? Yes No

If Yes, how do you plan to carry this out? _____

What is your child's feeding schedule? _____

Do you supplement? Yes No If Yes, with what and how often? _____

Is your child **bottle-fed**? Yes No

If **Yes**: What is your child's bottle feeding schedule? Please complete chart:

Liquids	Type	Amount	Times
Formula			
Milk			
Water			
Other:			

What position does your child like to be in while bottle-feeding? _____

What position does your child like to be in while being burped? _____

Does your child spit-up? Please comment: _____

Food continued on next page

Has your child been introduced to solids? Yes No If Yes, what type? Baby food Table food

What is your child's feeding schedule? Please complete chart. (Only list foods to which your child has successfully been introduced)

Solids	Type	Consistency	Amount	Times
Cereals				
Cereals				
Cereals				
Vegetables				
Vegetables				
Vegetables				
Vegetables				
Fruits				
Fruits				
Fruits				
Fruits				
Meats				
Meats				
Snacks				
Snacks				

Does your child have any food sensitivities? Yes No If Yes, please Identify: _____

Describe your child's appetite: _____

What foods does your child like and dislike? _____

Sleep

Describe your child's sleep routine (include times and lengths of naps) _____

Describe ways you help your child go to sleep (include position, special blanket, lighting, sound, etc.) _____

Does your child usually cry when going to sleep? Yes No If Yes, for how long? _____

Does your child usually cry when waking? Yes No

Where does your child usually sleep? Please describe: _____

Diapering

What type of diapers does your child use? _____

Describe your child's normal diapering routine (include double-diapering, liners, creams, powders etc.)

Is your child prone to diaper rash? Yes No Treatment used: _____

How many diapers would your child normally use between 8:00 a.m. and 5:00 p.m.? _____

Please comment on your child's bowel movements (including frequency, color, consistency, constipation, etc.)

Social/Emotional Development

Describe your child's temperament: (i.e. colic, likes to cuddle) _____

What signs does your child give of being hungry, tired or overstimulated? (i.e. pulls at ears, rubs eyes) _____

Does your child separate easily from you? Yes No Please comment: _____

Is your child afraid of anything? Yes No Please describe: _____

Does your child have a favorite toy, blanket, bottle or soother? Yes No Please identify: _____

Does your child spend time with other children? Yes No Please comment: (who, when, how much)

What activities does your child enjoy? _____

What activities does your child dislike? _____

Provide any further information relating to your child that would be helpful in understanding and caring for your child.

Note: Personal health information may be disclosed by the facility to the Ministry of Education in the course of reviewing the facility's record keeping obligations.

Date: _____
Year / Month / Day

Parent/Guardian signature

