Growing Together Family Resource Centre

Infant, Toddler, Preschool Child Information

Child's Name: _____ **Date:** _____

Relevant History (born premature, medical concerns, family dynamics, family customs you want the staff to be aware of and respect etc.)

_____

_____

_____

_____

Social and General

Does your child have any fears? (Dogs, sirens, loud noises) If yes, please explain; _____

_____

What makes your child angry or upset? How does s/he express those feelings**?** _____

_____

How do you comfort your child**?** _____

How do you reassure or reward your child**?** _____

Has your child been cared for by adults other than members of your family**?** _____

_____

Has your child had any previous group experience**?** If yes, please explain: _____

_____

_____

How does your child relate to adults**?** _____

How does your child relate to other children**?** _____

Are there any other languages spoken in the home**?** _____

What's your child's favourite activity at home**?** (e.g. books, solitary play, playing with a parent, outdoors etc.) _____

_____

Rest time

Does your child nap? Yes □ No □

Current napping schedule _____

Any concerns about rest time**?** _____

_____

What time does your child go to bed in the evening**?** _____ Awaken**?** _____

What is your child's mood upon waking**?** _____

What does your child take to bed**?** (Teddy bear, blanket etc.)_____

Does your child talk or cry out during sleep**?** _____

Does your child use a pacifier Yes □ No □_____

What word is used for naps or sleeping**?** _____

Please add additional information in regards to sleeping patterns for your child you would like us to know _____

_____

Eating

Child's favourite foods: _____

Foods that are refused: _____

Any concerns about eating habits**?** _____

_____

_____

Child Information

Infants

Bottles - Please describe your infant's current feeding and bottle schedule _____
_____
_____

How do you prepare your infant's bottle**?** _____
Is your baby's skin highly sensitive**?** Yes □ No □
Does your baby get frequent diaper rashes**?** Yes □ No □
Is diarrhea or constipation a concern**?** _____
How does your child go to sleep**?** (Rocked, in crib awake, music,) _____
_____

Toddlers

Are bowel movements regular? Yes □ No □ How many per day**?** _____
Any concerns with diarrhea /constipation**?** _____
Has toilet training been attempted Yes □ No □
Is your child trained for urine Yes □ No □ Bowel movements**?** Yes □ No □
Can your child indicate the need to use the washroom**?** Yes □ No □
What are the words used for urination**?** _____ Bowel movement**?** _____
Any particular words or expressions that may not be understood by the Early Childhood Educator _____
Please add any additional information you would like us to know. _____
_____
_____
_____

Preschoolers

Are bowel movements regular**?** Yes □ No □ How many per day**?** _____
Any concerns with diarrhea /constipation**?** _____
Has toilet training been attempted**?** Yes □ No □
Is your child able to use the toilet independently**?** E.g. remove clothing, clean him/herself, flush, wash hands etc.**?** Yes □ No □
_____
_____ *(Please comment on level of independence)*
Can your child indicate the need to use the washroom**?** Yes □ No □
What word is used for urination**?** _____ Bowel movements**?** _____
Any concerns about toileting**?** _____

Please add any additional information you would like us to know.
_____
_____
_____
_____
_____
_____

Parent/ Guardian (signature) _____ Date: _____