CHILD INFORMATION FORM

Child Name_____DOB_____

NickName_____ Address_____

Parent's Name, Place of Work and Phone Numbers:

_____

Parent's Name, Place of Work and Phone Numbers::

_____

Child's Ethnicity_____Child's First Language_____

Who Does the Child Live With_____

Parent Marital Status_____

Does your child have siblings Y N_____

_____

Does Your Child Nap?_____If so How Long?_____

Does your child toilet independently Y N

Wear Diapers Y N ifso daytime, nighttime or both?
Wear PullUps Y N ifso daytime, nighttime or both?

Does your child have any toileting difficulties we should know about?

Y N _____

What type of toys and activities does your child enjoy? _____
_____

Has your child ever been part of a daycare or group setting before?
Y N _____

Does your child accept new people and experiences easily? Y N

_____

Does your child have any fears? Y N _____
_____

How do you comfort your child?_____
_____

How do you discipline your child?_____
_____

Tell us why your child is special?_____
_____
_____

Anything Specific we should know to best care for your child?_____
_____
_____
_____

Tell us your goals for your child attending Little Sprouts Children's Center
_____
_____
_____