Toddler Information Form

Child's Name_____ Birthdate: _____

Parent's Signature: _____

Email Address: _____ Best Phone # to call: _____

Teacher's Signature: _____ Child's Class: _____

***(Please fill out front and back)***

1. Please describe your child's personality.

2. What types of activities does your child enjoy?

3. How do you feel your child will adjust to the toddler room?

4. What things do you find help to calm your child when he or she is upset?

5. What are your child's favorite toys?

6. Does your child have any fears? If so, what are they and how do they show their fear?

7. What makes your child frustrated or upset?

8. What kinds of previous experiences has your child had with groups of children?

9. Describe your family's cultural background, home language, family traditions, and customs.

10. Were there any unusual circumstances that occurred during your child's birth, i.e., premature, complications?

11. How well does your child get along with other children?

12. Are there any changes happening in your home that would affect your child; recent marriage, recent or upcoming move, new/birth/adoption, death, divorce, abuse, family counseling? Please be sure to let us know if any changes in the home come up.

13. What types of discipline are effective with your child?

14. Does your child seem well most of the time? Yes / No

15. Is your child taking any medications currently? Yes / No and Why?

16. Please list any food allergies or dietary restrictions.

17. Did your child have as many as three ear infections in the last year? Yes / No

18. Are you concerned about your child's hearing? Yes/ No

19. Are you concerned about your child's eyes or vision? Yes / No

20. Has your child ever been seen by a medical specialist? Yes / No and Why?

21. What arrangements have you made if he/she becomes ill at the center?

22. Does your child have any handicaps / delays? Please describe.

23. Other illnesses or diseases? Please describe.

24. Has your child ever been hospitalized? Yes / No Please Describe.

25. Has your child had any of the following? Please circle. Head Injury / Seizures / Trouble Breathing / Allergies (eczema, hives, medications, wheezing, food intolerances, asthma, insect bites)

26. Do you have any specific ways of helping your child go to sleep? Describe.

27. What is your child's present sleep schedule?

Nighttime from _____ to _____
Afternoon Nap from _____ to _____

28. Does your child use a pacifier?

29. Does your child have a special blanket?

30. Does your child need a special toy to sleep?

31. Does your child have any feeding issues? Please describe.

32. How frequently does your child have bowel movements?

33. Has your child had a history of biting, or have they ever been bitten by another child?

34. What name or nickname do you want your child to begin to recognize?