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|---|-----------------------------|------------------------|----------------------|
| Child Name (last, first, middle) | Social Security No.* | Enrollment Date | Date of Birth |
| Street Address (if rural, attach directions) | City | County | Zip |
| Mailing Address (if different) -- Street or P.O. Box | City | County | Zip |
| Telephone No. (include A/C) | | | |

* If applicable.

1. Health

| | | |
|---|------------------------------|-----------------------------|
| Does your child have any allergies? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| If so, what allergies does your child have? | | |
| How should we respond if he/she has an allergic reaction? | | |
| Does your child have an existing illness? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Has your child had a previous serious illness or injury, or hospitalization during the past 12 months? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Is your child taking any medication? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| If so, how is the medication administered, and will it need to be administered while he/she is in care? | | |
| Is the medication prescribed for continuous use? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Are there any side effects we should be alerted to? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

2. Toileting:

| | | |
|---|------------------------------|-----------------------------|
| Does your child need assistance with toileting? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| How can we best help? | | |
| What are your ideas about toilet training? | | |
| How can we best help? | | |

3. Behavior:

| | | |
|---|------------------------------|-----------------------------|
| Does your child have any special fears? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| How does your child communicate his/her needs? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Are there any special words that your child uses that might not be readily recognized? | | |
| How do you tell your child to stop a behavior that you don't approve of or that might be dangerous? | | |
| When your child gets upset, what helps him/her calm down? | | |
| What is a good way to distract your child when he/she is having a temper tantrum? | | |
| Are there any particular routines that are particularly helpful at naptime? | | |

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| What position is most comfortable for your child when he/she is napping? | |
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4. Eating Preferences:

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| What are your child's favorite foods? | |
| Does your child use utensils, eat with fingers, feed self? | |
| Does your child choke easily while eating? | <input type="checkbox"/> Yes <input type="checkbox"/> No |

5. Activities:

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| What activities do you like to do with your child? | |
| What activities does your child like to do when playing with other children? | |
| What does your child like to do when he is playing alone? | |

6. Family History:

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|---|--|
| Tell me about your family (i.e. child's parents, siblings, grandparents, and other extended family) | |
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I verify that the above assessment was discussed with the parent(s) of _____

Signature of Director Date Signed

I verify that the director appropriately relayed the information concerning my child's assessment.

Signature of Parent Date Signed

Additional Comments:

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