

UPDATES

By providing complete information about your child, you will be assisting our staff in creating a positive experience for him / her while in our care. List any information about your child's habits, abilities, or personality that you feel will be helpful to the staff while caring for your child.

**PARENT SIGNATURE:** \_\_\_\_\_ **DATE SIGNED:** \_\_\_\_\_

Does child have a fussy time?    Yes    No    If "Yes" – Specify time.

How is fussy time handled?

Child likes to be: Held    Sung to    Rocked    Read to    Other – Specify: \_\_\_\_\_

Special things you say or do to comfort child:

UPDATES

**SELF-EXPRESSION**

What causes your child to feel angry or frustrated?

What frightens your child and how is it shown?

How does your child express feelings of happiness, enjoyment, etc.?

Additional comments

UPDATES

**PHYSICAL AND SOCIAL DEVELOPMENT**

Is your child able to – (Check all that apply)    Sit up alone    Pull up    Crawl  
Walk holding on    Walk without support

Is your child used to playmates?    Yes    No

Comments:

**MISCELLANEOUS**

Child's **indoor** favorite toys and activities – Specify.

Child's **outdoor** favorite toys and activities – Specify.

**SLEEP**

Current sleep schedule: \_\_\_\_\_ Length of time on current schedule: \_\_\_\_\_

Falls asleep easily: Yes No

Mood upon awakening – Describe:

Takes favorite toy(s) to bed – **child over age 1 year** Yes No If "Yes" – list toy(s): \_\_\_\_\_

Sleep position – **child under age 1 year**

**Note:** Children under age 1 year must be placed to sleep on their back unless a written statement from the child's physician is attached. Back for children under age 1 year Side or stomach (physician statement attached)

Sleep position – **child over age 1 year** Back Side Stomach

UPDATES

**DIAPERING / TOILETING**

Diaper – type: Cloth Disposable Diapers provided by parent: Yes No

Plastic pants used: Always Never Sometimes If "Sometimes" – Specify: \_\_\_\_\_

Highly sensitive skin: Yes No

Frequent diaper rash: Yes No

Oil, powder or lotion used: Yes No If "Yes", product name(s) – Specify: \_\_\_\_\_

Toilet training attempted: Yes No If "Yes", describe routine: \_\_\_\_\_

Type of toilet seat used at home: Potty chair Special toilet seat Regular toilet seat

Regular bowel movements: Yes No How often? Time(s) of day: \_\_\_\_\_

Toileting problems: Yes No If "Yes" – Describe: \_\_\_\_\_

UPDATES

**VERBAL COMMUNICATION**

Family speaks what language – Specify: English Other If "Other" – Specify: \_\_\_\_\_

Age child began talking: \_\_\_\_\_ Child speaks in: Words Sentences

Words used to describe special needs – Specify.

UPDATES

**COMFORTING**

**Zion Lutheran Child Care Center**

N48 W18700 Lisbon Road  
Menomonee Falls, WI 53051  
262-781-6719



First Day of Attendance (mm/dd/yyyy)

\_\_\_\_\_

**PARENT / CHILD NAME AND ADDRESS**

Name – Child (Last, First, MI)

Nickname (If any)

\_\_\_\_\_

Birthdate (mm/dd/yyyy)

Name – Parent(s) (Last, First, MI)

\_\_\_\_\_

Telephone Number – Home

Address – Parent(s) (Street, City, State, Zip Code)

\_\_\_\_\_

**HEALTH**

Child has frequent colds, ear infections, colic, etc. – Describe.

**UPDATES**

**MEALS**

Current feeding schedule: \_\_\_\_\_

\_\_\_\_\_

Length of time on current schedule: \_\_\_\_\_

Food type:      Formula      Strained      Junior Table      Milk type – Specify:

New food timetable: \_\_\_\_\_

When eating, child is:      Held in lap      In highchair      Other – Specify:

Feeds self:      Yes      No      If "Yes", uses:      Spoon      Fork      Hands

Special feeding problems:      Yes      No      If "Yes" – Specify: \_\_\_\_\_

Food allergies:      Yes      No      If "Yes" – Specify: \_\_\_\_\_

Favorite foods – Specify. \_\_\_\_\_

Refused foods – Specify. \_\_\_\_\_

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