Apple Dumpling
Learning Center, LLC
348 S Commerce Ave.
Front Royal, VA 22630

Child	Nickname	Date of Birth	Sex
Address			Home Phone
Chronic Physical Problems/Pertinent Developmental Information/Special Accommodations Needed			
Previous Child Day Care Programs and Schools Attended			
If Child Attends this Center and Another School/Program, Give Name of School/Program			Grade or Class Level

PARENT(S)/GUARDIAN(S)

Parent	Place Employed	Work Phone
Home Address		Home Phone
Parent	Place Employed	Work Phone
Home Address		Home Phone
Person(s) or Agency Having Legal Custody of Child		
Home Address		Home Phone
Work Address		Work Phone

EMERGENCY INFORMATION

Allergies or Intolerance to Food, Medication, etc., and Action to Take in an Emergency		
Child's Physician		Phone
Two People To Contact if Parent(s) Cannot Be Reached 1.	Address 1.	Phone 1.
2.	2.	2.
Person(s) Authorized To Pick Up Child		
Person(s) NOT Authorized To Pick Up Child*		

- Appropriate paperwork such as custody papers shall be attached if a parent is not allowed to pick up the child.
- NOTE: Section 22.1-4.3 of the *Code of Virginia* states that unless a court order has been issued to the contrary, the noncustodial parent of a student enrolled in a public school or day care center (i) shall not be denied the opportunity to participate in any of the student's school or day care activities in which such participation is supported or encouraged by the policies of the school or day care center solely on the basis of such noncustodial status and (ii) shall be included, upon the request of such noncustodial parent, as an emergency contact for the student's school or day care activities.

(over)

AGREEMENTS

1. The child day center agrees to notify the parent(s)/guardian(s) whenever the child becomes ill and the parent(s)/guardian(s) will arrange to have the child picked up as soon as possible if so requested by the center.

2. The parent(s)/guardian(s) authorize the child day center to obtain emergency medical care if any emergency occurs when the parent(s)/guardian(s) cannot be located immediately. **

3. The parent(s)/guardians agree to inform the center within 24 hours or the next business day after his child or any member of the immediate household has developed a reportable communicable disease, as defined by the State Board of Health, except for life threatening diseases which must be reported immediately.

SIGNATURES

_____ _____

Parent(s) or Guardian(s) *Date*

_____ _____

Administrator of Center *Date*

First Date of Attendance: _____ Last Date of Attendance: _____

** If there is an objection to seeking emergency medical care, a statement should be obtained from the parent(s) or guardian(s) that states the objection and the reason for the objection.

OFFICE USE ONLY
IDENTITY VERIFICATION

If proof of identity is required and a copy is not kept, please fill out the following.

Place of Birth	Birth Date	Birth Certificate Number	Date Issued
Other Form of Proof		Date Documentation Viewed	Person Viewing Documentation

Date of Notification of Local Law-Enforcement Agency (when required proof of identity is not provided):

_____

Date

Proof of the child's identity and age may include a certified copy of the child's birth certificate, birth registration card, notification of birth (hospital, physician or midwife record), passport, copy of the placement agreement or other proof of the child's identity from a child placing agency (foster care and adoption agencies), record from a public school in Virginia, certification by a principal or his designee of a public school in the U. S. that a certified copy of the child's birth record was previously presented or copy of the entrustment agreement conferring temporary legal custody of a child to an independent foster parent. Viewing the child's proof of identity is not necessary when the child attends a public school in Virginia *and* the center assumes responsibility for the child directly from the school (i.e., after school program) or the center transfers responsibility of the child directly to the school (i.e., before school program). While programs are not required to keep the proof of the child's identity, documentation of viewing this information must be maintained for each child.

Section § 22.1-289.049 of the Code of Virginia states that the proof of identity, if reproduced or retained by the child day program or both, shall be destroyed upon the conclusion of the requisite period of retention. The procedures for the disposal, physical destruction, or other disposition of the proof of identity containing social security numbers shall include all reasonable steps to destroy such documents by (i) shredding, (ii) erasing, or (iii) otherwise modifying the social security numbers in those records to make them unreadable or indecipherable by any means..

COMMONWEALTH OF VIRGINIA
SCHOOL ENTRANCE HEALTH FORM
Health Information Form/Comprehensive Physical Examination Report/Certification of Immunization

Part I – HEALTH INFORMATION FORM

State law (Ref. Code of Virginia § 22.1-270) requires that your child is immunized and receives a comprehensive physical examination before entering public kindergarten or elementary school. **The parent or guardian completes this page (Part I) of the form.** The Medical Provider completes Part II and Part III of the form. This form must be completed no earlier than one year before your child's entry into school.

Name of School: _____ Current Grade: _____

Student's Name: _____ _____ _____
Last First Middle

Student's Date of Birth: ____/____/_____ Sex: _____ State or Country of Birth:_____Main Language Spoken: _____

Student's Address_____ City_____ State_____ Zip Code_____

Name of Parent or Legal Guardian 1:_____Phone:_____-_____-_____Work or Cell: _____-_____-_____

Name of Parent or Legal Guardian 2:_____Phone:_____-_____-_____Work or Cell: _____-_____-_____

Emergency Contact:_____Phone:_____-_____-_____Work or Cell: _____-_____-_____

Hospital Preference: _____

Child's Health Insurance: None☐ FAMIS Plus (Medicaid) ☐ FAMIS☐ Private/Commercial/ Employer Sponsored☐_____

Box 1. Pre-Existing Conditions

Condition	Yes	Comments	Condition	Yes	Comments
Allergies (food, insects, drugs, latex) Please list **Life Threatening Allergies**:			Diabetes: Type 1		
			Diabetes: Type 2		
			Insulin pump		
Allergies (seasonal)			Head injury, concussion		
Asthma or breathing conditions			Hearing conditions or deafness		
Attention-Deficit/Hyperactivity Disorder			Heart conditions		
Behavioral/Psych/ Social conditions			Lead poisoning		
Developmental conditions			Muscle conditions		
Bladder conditions			Seizures		
Bleeding conditions			Sickle Cell Disease (not trait)		
Bowel conditions			Speech conditions		
Cerebral Palsy			Spinal injury		
Cystic fibrosis			Surgery		
Dental Health conditions			Vision conditions		

Describe any other important health-related information about your child (☐ Feeding tube , ☐ Trach , ☐Oxygen support, ☐ Hearing aids, ☐ Dental appliance, ☐ Wheelchair, Hospitalizations, etc.):

Box 2. Medications

List all prescription, emergency, over-the-counter, and herbal medications your child takes regularly (Home/ School):

Medication Name	Dosage	Time Administered (Home/School)	Notes
1.			
2.			
3.			
4.			

Additional Medications (Name, Dose, Time Administered, Notes)

Check here if you want to discuss confidential information with the school nurse or other school authority. Yes No Please provide the following information:

	Name	Phone	Date of Last Appointment
Pediatrician/primary care provider			
Specialist			
Dentist			
Case Worker (if applicable)			

I*_____*(do) (do not) authorize my child's health care provider and designated provider of health care in the school setting to discuss my child's health concerns and/or exchange information pertaining to this form. This authorization will be in place until or unless you withdraw it. You may withdraw your authorization at any time by contacting your child's school. When information is released from your child's record, documentation of the disclosure is maintained in your child's health or scholastic record.

Signature of Parent or Legal Guardian:_____Date:_____/_____/_____

Signature of Interpreter: _____Date____/____/_____

COMMONWEALTH OF VIRGINIA
SCHOOL ENTRANCE HEALTH FORM
Part II - Certification of Immunization

Check if the student's Immunization Records are attached using a separate form signed by HCP ☐

Section I

See Section II for conditional enrollment and exemptions.

A copy of the immunization record signed or stamped by a physician or designee, registered nurse, or health department official indicating the dates of administration including month, day, and year of the required vaccines shall be acceptable in lieu of recording these dates on this form as long as the record is attached to this form. Form must be signed and dated by the Medical Provider or Health Department Official in the appropriate box. Please contact your local health department for assistance with foreign vaccine records.

Student Name: **Date of Birth :** / / **Sex:**

Race (Optional): **Ethnicity:** ☐ **Hispanic** ☐ **Non-Hispanic**

IMMUNIZATION	RECORD COMPLETE DATES (month, day, year) OF VACCINE DOSES GIVEN				
Diphtheria, Tetanus, Pertussis Vaccine (DTP, DTaP)	1	2	3	4	5
Diphtheria, Tetanus (DT) or Tdap or Td Vaccine (given after 7 years of age)	1	2	3	4	5
Tdap Vaccine booster	1				
Poliomyelitis Vaccine (IPV, OPV)	1	2	3	4	5
Haemophilus influenzae Type b Vaccine (Hib conjugate) only for children <60 months of age	1	2	3	4	
Rotavirus Vaccine (RV) only for children < 8 months of age	1	2	3		
Pneumococcal Vaccine (PCV conjugate) only for children <60 months of age	1	2	3	4	
Varicella Vaccine	1	2	Date of Varicella Disease OR Serological Confirmation of Varicella Immunity:		
Measles, Mumps, Rubella Vaccine (MMR vaccine)	1	2			
Measles Vaccine (Rubeola)	1	2	Serological Confirmation of Measles Immunity:		
Rubella Vaccine	1	2	Serological Confirmation of Rubella Immunity:		
Mumps Vaccine	1	2	Serological Confirmation of Mumps Immunity:		
Hepatitis B Vaccine (HBV) ☐ Merck adult formulation used	1	2	3	4	
Hepatitis A Vaccine	1	2			
Meningococcal **ACWY** Vaccine	1	2			
Meningococcal B Vaccine	1	2	3		
Human Papillomavirus Vaccine (HPV)	1	2	3		
Influenza (Yearly)	1	2	3	4	5
Other	1	2	3	4	5
Other	1	2	3	4	5

Certification of Immunization

I certify that this child is **ADEQUATELY OR AGE APPROPRIATELY IMMUNIZED** in accordance with the MINIMUM requirements for attending school, child care or preschool prescribed by the State Board of Health's *Regulations for the Immunization of School Children* (Reference Section III).

Signature of Medical Provider or Health Department Official: _____ **Date (*Mo., Day, Yr.*):** 12 / / ____

Section II
Conditional Enrollment and Exemptions

Complete the medical exemption or conditional enrollment section as appropriate to include signature and date. This section must be attached to Part I Health Information (to be filled out and signed by parent).

Student's Name: _____ Date of Birth: |___|___|___|

Parent or Legal Guardian Name: _____

Parent or Legal Guardian Name: _____

Phone Number: _____

MEDICAL EXEMPTION: As specified in the *Code of Virginia* § 22.1-271.2, C (ii), I certify that administration of the vaccine(s) designated below would be detrimental to this student's health. The vaccine(s) is (are) specifically contraindicated because (please specify):

_____

_____

_____

DTP/DTaP/Tdap :[____]; DT/Td:[____]; OPV/IPV:[____]; Hib:[____]; PCV:[____]; RV:[____]; Measles :[____];

Mumps:[____]; Rubella :[____]; VAR:[____]; Men ACWY:[____]; Men B:[____]; Hep A:[____]; HBV:[____]

This contraindication is permanent: [ ], or temporary [ ] and expected to preclude immunizations until: Date (*Mo., Day, Yr.*): |_____|_____|_____.

Signature of Medical Provider or Health Department Official:_____ Date (*Mo., Day, Yr.*):___/___/___

RELIGIOUS EXEMPTION: The *Code of Virginia* allows a child an exemption from receiving immunizations required for school attendance if the student or the student's parent/guardian submits an affidavit to the school's admitting official stating that the administration of immunizing agents conflicts with the student's religious tenets or practices. Any student entering school must submit this affidavit on a CERTIFICATE OF RELIGIOUS EXEMPTION (Form CRE-1), which may be obtained at any local health department, school division superintendent's office or local department of social services. Ref. *Code of Virginia* § 22.1-271.2, C (i).

CONDITIONAL ENROLLMENT: As specified in the *Code of Virginia* § 22.1-271.2, B, I certify that this child has received at least one dose of each of the vaccines required by the State Board of Health for attending school and that this child has a plan for the completion of his/her requirements within the next 90 calendar days. Next immunization due on_____.

Signature of Medical Provider or Health Department Official:_____ Date (*Mo., Day, Yr.*):|___|___|___|

Section III Requirements

For Minimum Immunization Requirements for Entry into School and Day Care, consult the Division of Immunization web site at http://www.vdh.virginia.gov/epidemiology/immunization

Children shall be immunized in accordance with the Immunization Schedule developed and published by the Centers for Disease Control (CDC), Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP), otherwise known as ACIP recommendations (Ref. *Code of Virginia* § 32.1-46(a)).

(Requirements are subject to change.)

...ling Learning Center _____Office Updated

Part III – COMPREHENSIVE PHYSICAL EXAMINATION REPORT

A qualified licensed physician, nurse practitioner, or physician assistant must complete Part III. The exam must be done no longer than one year before entry into kindergarten or elementary school (Ref. Code of Virginia § 22.1-270). Instructions for completing this form can be found at www.vahealth.org/schoolhealth.

Student's Name: _____ Date of Birth: ___/___/___ Sex: M F

Health Assessment

Date of Assessment: ___/___/___

Weight:_____lbs. Height:_____ft._____in.

Body Mass Index (BMI):_____BP_____

- ☐ Age / gender appropriate history completed
- ☐ Anticipatory guidance provided

Physical Examination

1 = Within normal 2 = Abnormal finding 3 = Referred for evaluation or treatment

	1	2	3		1	2	3		1	2	3	
HEENT				Neurological				Skin				
Lungs				Abdomen				Genital				
Heart				Extremities				Urinary				

Tuberculosis Screening

Check the box that applies:

☐ No risk for TB infection identified	☐ No symptoms compatible with active TB disease	☐ Risk for TB infection or symptoms identified

Test for TB Infection: TST IGRA Date:_____ TST Reading____ mm TST/IGRA Result: ☐ Negative ☐ Positive
CXR required if positive test for TB infection or TB symptoms. CXR Date:_____ Normal _ Abnormal

EPSDT Screens Required for Head Start – include specific results and date:

Blood Lead:_____ Hct/Hgb _____

Developmental Screen

Assessed for:	*Assessment Method:*	*Within normal*	*Concern identified:*	*Referred for Evaluation*
Emotional/Social				
Problem Solving				
Language/Communication				
Fine Motor Skills				
Gross Motor Skills				

Hearing Screen

☐ Screened at 20dB: Indicate Pass (P) or Refer (R) in each box.
☐ Screened by OAE (Otoacoustic Emissions): ☐ Pass ☐ Referred

	1000	2000	4000
R			
L			

☐ Referred to Audiologist/ENT ☐ **Unable to test – needs rescreen**
☐ Permanent Hearing Loss Previously identified: ☐ Left ☐ Right
☐ Hearing aid or another assistive device

Vision Screen

☐ With Corrective Lenses (Check if yes)

Stereopsis ☐ Pass ☐ Fail				☐ Not tested
Distance	Both	R	L	Test used:
	20/	20/	20/	

☐ Pass ☐ Referred to eye doctor ☐ **Unable to test-needs rescreen**

Dental Screen

☐ Problems Identified: Referred for Treatment
☐ No Problem: Referred for prevention
☐ No Referral: Already receiving dental care
☐ **Unable to perform**

Recommendations to (Pre) School, Child Care, or Early Intervention Personnel

Summary of Findings (check one):

☐ Well child; no conditions identified of concern to school program activities
Conditions identified that are important to schooling or physical activity (complete sections below and/or explain here):

_____

____**Allergy:** ☐ food:_____ ☐ insect:_____ ☐ medicine:_____ ☐ other:_____
Type of allergic reaction: ☐ *anaphylaxis* ☐ *local reaction* *Response required:* ☐ *none* ☐ *epinephrine auto-injector* ☐ other::____
____**Individualized Health Care Plan needed** (e.g., asthma, diabetes, seizure disorder, severe allergy, etc)
____**Restricted Activity Specify:** :_____
____**Developmental Evaluation** ☐ Has IEP ☐ Further evaluation needed for: _____
____**Medication.** Child takes medicine for specific health condition(s). ☐ Medication must be given and/or available at school.
____**Special Diet Specify:** _____
____**Special Needs Specify:**_____
Other Comments:_____

Health Care Professional's Certification (Write legibly or stamp) ☐ **By checking this box, I certify with an electronic signature that all of the information entered above is accurate (enter name and date on signature and date lines below).**

Name:_____ **Signature:**_____
Practice/Clinic Name: _____ **Address:**_____
Phone:_____-_____-_____ **Fax:** _____-_____-_____ **Email:**_____

Apple Dumpling Learning Center _____Office Updated

Emergency Form

Child's

Last_____First_____M.I_____

D.O.B_____Gender_____

Address_____

_____

Mother's

Last_____First_____M.I_____

D.O.B_____ Gender_____ Email_____

Address_____

_____

Cell Phone_____

Work Phone_____

Father's

Last_____First_____M.I_____

D.O.B_____ Gender_____Email_____

Address_____

_____

Cell Phone_____

Work Phone_____

Emergency Contact's

Name _____Phone_____

Address_____

_____

Relationship to child_____

Name _____ Phone _____

Address _____

_____

Relationship to child _____

Name _____ Phone _____

Address _____

_____

Relationship to child _____

Please list anyone else that can pick up and their relationship to the child:

_____

_____

_____

_____

Please list anyone that CANNOT pick up your child :

_____

_____

_____

_____

_____

ENROLLMENT PACKET

Please fill out these forms completely. If a question does not apply to your child, write N/A (not applicable). The forms must be in the director's possession on or before the first day your child begins care. Please notify your director if any of the information changes.

GENERAL INFORMATION

Child's Full Name:_____ Date of Birth:_____

Child's Nickname:_____ Sex:_____ Race:_____

Hair Color:_____ Eye Color:_____ Height:_____ Weight:_____

Primary Language of Child:_____ Primary Language of Parents:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Days Of Care: Mon Tues Wed Thurs Fri Hours of Care: From_____ To_____

Parent/Guardian's Name:_____ Relationship to Child:_____

Home Address (if different):_____

Home Phone:_____ Cell Phone:_____

Email Address:_____

Employer:_____ Work Phone:_____

Parent/Guardian's Name:_____ Relationship to Child:_____

Home Address (if different):_____

Home Phone:_____ Cell Phone:_____

Email Address:_____

Employer:_____ Work Phone:_____

EMERGENCY CONTACT INFORMATION/ALTERNATE PICK-UP FORM

In the event of an emergency when I may not be reached, the director may contact the following individuals (in the order given) whom I authorize to take my child from the child care premises.

(1) Name:_____ Relationship to Child:_____

Home Addres:_____

City:_____ State:_____ Zip Code:_____

Home Phone:_____ Cell Phone:_____

Work Phone:_____ Allowed to Pick-Up My Child: Yes_____ No_____

(2) Name:_____ Relationship to Child:_____

Home Addres:_____

City:_____ State:_____ Zip Code:_____

Home Phone:_____ Cell Phone:_____

Work Phone:_____ Allowed to Pick-Up My Child: Yes_____ No_____

(3) Name:_____ Relationship to Child:_____

Home Addres:_____

City:_____ State:_____ Zip Code:_____

Home Phone:_____ Cell Phone:_____

Work Phone:_____ Allowed to Pick-Up My Child: Yes_____ No_____

*Attach copies of any custody agreements, court orders, restraining orders (if applicable). Please note what paperwork you have attached to this enrollment packet:_____

Parent/Guardian's Name Printed:_____

Parent/Guardian's Signature:_____

Date:_____

DEVELOPMENTAL HISTORY & BACKGROUND INFORMATION

PERSONAL HISTORY

Any Siblings?_____ Number of Siblings: Brothers_____ Sisters_____

Sibling Name(s)_____

Do you have pets?_____ Name(s)_____ Type(s)_____

Has your child had any other child care experiences?_____

What types of activities do you do together with your child?_____

_____

What type of things does your child do well?_____

_____

What are your child's special interests?_____

What are your child's dislikes?_____

Is your child enrolled in any classes?_____ Type of class_____

Are other languages spoken around the child?_____ Which?_____

Age he/she began: Sitting_____ Crawling_____ Walking_____ Talking_____

Is he/she a good climber?_____ Does he/she fall easily?_____

Does he/she speak in words?_____ Sentences?_____ Does he/she have difficulty speaking?_____

Special words to describe his/her need(s)_____

EATING HABITS

At what time does your child normally eat meals?: Breakfast_____ Lunch_____

Dinner_____ Snack time(s)_____

What are his/her favorite foods?_____

What foods are refused?_____

Does your child have food allergies?_____ What are they?_____

Does your child have any problems eating?_____ Explain_____

_____

TOILET HABITS

Toilet training started?_____ Accomplished?_____ Is/Was the process easy or difficult?_____

Please describe any particular procedure you are using to toilet train:_____

_____

Can your child be relied upon to indicate his/her bathroom needs?_____

What word is used for urination?_____ Bowel movements?_____

Does your child need assistance in the bathroom?_____ Is he/she afraid of the bathroom?_____

Does your child need to go to the bathroom more frequently than normal for his/her age?_____

Does the child wet the bed when sleeping?_____ If so, how often?_____

Are disposable or cloth diapers, or pull-ups used? _____

Is there a frequent occurrence of diaper rash? _____ How is it treated?_____

Are bowel movements regular? _____ How many per day? _____

Is there a problem with diarrhea? _____ Constipation? _____

Is your child ever reluctant to use the bathroom?_____

SLEEPING HABITS

When is bedtime?_____ Wake up ?_____

What does he/she usually take to bed with him/her?_____

What is his/her mood upon awakening?_____

Does your child become tired or nap during the day (include when and how long)?_____

_____

Does he/she have his/her own room?_____Own bed?_____ Still Sleeps in Crib?_____

Does he/she walk, talk or cry during sleep? _____ Please describe:___

_____

SOCIAL RELATIONSHIPS

Has your child had any experience playing with other children?_____

How does he/she get along with siblings?_____

Does your child prefer to play alone or with children his/her own age?_____

Does he/she know any other children in this daycare center?_____

How does he/she react to unfamiliar adults?_____

Does your child demand a lot of adult attention?_____

What makes him/her mad or upset?_____

How does your child show feelings?_____

What do you find is the best way of comforting your child?_____

What methods of discipline are used at home? Explain._____

_____

What type of physical activities does your child enjoy?_____

_____

Is your child frightened of any of the following?: Animals_____ Unfamiliar adults_____ Storms_____

Other children_____ Loud noise_____ The dark_____ Storms_____ Insects/bees_____

Other:_____

What activities does your child enjoy?: Being read to_____ Listening to music_____ Puzzles_____

Painting/drawing_____ Playing outdoors_____ Building with blocks_____ Painting/drawing_____

Clay/dough_____ Other:_____

Briefly describe your child's personality traits and abilities._____

_____

_____

What would you like your child to gain from this child care experience?_____

_____

MEDICAL HISTORY

Please notify the director if any of the following information changes. Also, have your child's doctor to update our Child Health Report form.

Does your child have any medical conditions we should be aware of?_____

_____

_____

Does your child need medication for his/her medical condition(s)? Please check one: Yes_____ No_____
If you checked 'yes', please see Medication Log form.

Does your child have any known allergies? Please List._____

_____

Special instructions in the event of an allergic reaction:_____

_____

Does your child have any speech, hearing or visual problems?_____

Does your child have any mental or physical disabilities?_____

Would there be any restrictions to play or activities?_____

Does your child have any problems with any of these? (Please Circle)

Constipation
Convulsions
Diarrhea
Fainting Spells
Frequent Colds
Frequent Ear Infections
Frequent Sore Throats
Lice
Ringworm
Skin Rash
Soiling
Stomach Upsets
Urinary Problem
Worms

Has your child had any of these diseases? (Please Circle)

Asthma
Bronchitis
Chicken Pox
Diabetes
Heart Disease
Hepatitis
Impetigo
Measles
Mumps
German Measles
Polio
Scarlet Fever
Tuberculosis
Whooping Cough

THANK YOU FOR SHARING THIS HELPFUL INFORMATION WITH US SO WE CAN BETTER UNDERSTAND THE INDIVIDUALITY OF YOUR CHILD.

Parent/Guardian Signature:_____ Date:_____

Infant Social Resume

Child's Name: _____

Food

Is your child breast-fed? ___Yes ___No
If yes:

Do you plan to continue breast feeding? ___Yes ___No
What is your child's feeding schedule? _____

_____

_____

Do you supplement? ___Yes ___No

Is your child bottle fed? ___Yes ___No
If yes: What is your child's bottle feeding schedule?

Liquids	Type	Amount	Times
Formula			
Milk			
Water			

What position does your child like to be in while bottle feeding?

_____

What position does your child like to be in while being burped?

_____

Has your child been introduced to solids? ___Yes ___No
If yes: What type? ___baby food ___table food

What is your child's feeding schedule?

Solids	Type	Amount	Times
Cereal			
Vegetable			
Vegetable			
Fruit			
Fruit			
Meat			

Does your child have any food sensitivities? ___Yes ___No
If yes: Please identify: _____

_____

What foods does your child like/dislike? _____

_____

Sleep

Describe your child's sleep routine (include naps & lengths of naps):

_____

_____

Does your child usually cry when going to sleep? ___Yes ___No
Where does your child normally sleep? _____

Diapering

What type of diapers does your child use? _____
Does your child use creams, powders, etc? ___Yes ___No
Is your child prone to diaper rash? ___Yes ___No
Treatment: _____

Social/Emotional Development

Describe your child's temperament: (colic, likes to cuddle, etc) _____

_____

What signs does your child give when hungry, tired, or over stimulated?

_____

Does your child separate easily from you? ___Yes ___No
Is your child afraid of anything? ___Yes ___No
Please explain: _____
Does your child have a favorite blanket, toy, or soother? ___Yes ___No
If yes, describe: _____

Please provide any additional information that would be helpful in caring for your child:

Toddler Social Resume

Child's Name: _____

Family

Does your child have pets? If so, what are they? _____

_____

Food

Describe your child's appetite: _____

_____

Does your child have any food sensitivities? ___Yes ___No

If yes, please describe: _____

_____

Is your child under medical care for this allergy? ___Yes ___No

Self-Care

Is your child in diapers? ___Yes ___No Comment: _____

Has training begun? ___Yes ___No Comment: _____

Is your child trained? ___Yes ___No Comment: _____

Does child need help? ___Yes ___No Comment: _____

Sleep

Describe your child's sleep routine (include naps & lengths of naps):

_____

Social/Emotional Development

Does your child separate easily from you? ___Yes ___No

How do you handle discipline in your home? _____

_____

Please provide any additional information that would be helpful in caring for your child: _____

_____

_____

Preschool/Pre-K Social Resume

Child's Name: _____

Food

Describe your child's appetite: _____

_____

Does your child have any food sensitivities? ___Yes ___No

If yes, please describe: _____

_____

Self-Care

Is your child trained? ___Yes ___No Comment: _____

Does child need help? ___Yes ___No Comment: _____

Sleep

Describe your child's sleep routine (including lengths of naps):

_____

Social/Emotional Development

Does your child separate easily from you? ___Yes ___No

Is your child afraid of anything? ___Yes ___No

If yes, explain: _____

Does your child have a favorite toy, blanket, or soother? ___Yes ___No

If yes, explain: _____

Does your child spend time with other children? ___Yes ___No

Does your child have any pets? ___Yes ___No

How do you handle discipline in your home? _____

_____

Please provide any additional information that would be helpful in caring for your child: