



"Where Every Moment is a Tender Time"

## INFANT / TODDLER PERSONAL INFORMATION

Child's Full Name \_\_\_\_\_ Nickname: \_\_\_\_\_

Date of Birth \_\_\_\_\_ Today's Date \_\_\_\_\_

### PERSONALITY

What does your child like to do or play with? \_\_\_\_\_

Briefly describe your child's behavior: \_\_\_\_\_

What makes your child angry or upset? \_\_\_\_\_

How does your child show feelings or communication? \_\_\_\_\_

What do you find is the best way of handling your child? \_\_\_\_\_

Are there any special requirements you have for Tender Time pertaining to the care of your child? \_\_\_\_\_

Please indicate which words you feel are **most** applicable to your child:

_____ Cheerful	_____ Shy	_____ Sensitive	_____ Happy
_____ Quiet	_____ Independent	_____ Apprehensive	_____ Trusting
_____ Energetic	_____ Colicky	_____ Talkative	_____ Other

Please list all family members/pets in the home \_\_\_\_\_

Has your child ever attended another daycare or home daycare? \_\_\_\_\_

If yes, what type? \_\_\_\_\_ How was the experience? \_\_\_\_\_

### EATING

Is your child breast fed, formula fed, both, or off the bottle? \_\_\_\_\_

What kind of milk (breast milk, formula, whole milk) will we be serving your child? \_\_\_\_\_

If formula, which kind? \_\_\_\_\_ Will you keep bottles and formula here or bring filled bottles daily? \_\_\_\_\_

If your child doesn't finish a *breast* milk bottle, should Tender Time:

\_\_\_\_\_ Discard the rest of the breast milk      \_\_\_\_\_ Discard the rest of the breast milk unless 2 or more ounces are left over. (We can keep the breast milk bottle at room temperature and reuse at the next feeding, not to exceed 4 hours.)

How does your child burp the easiest? \_\_\_\_\_

Does your infant ever spit-up after being burped? \_\_\_\_\_ How much? \_\_\_\_\_

Does your child use a sippy cup? \_\_\_\_\_ Does your child feed them self? \_\_\_\_\_

Does your child have any feeding problems? \_\_\_\_\_

Please give an example of a full day's eating habits (type of food and amount): \_\_\_\_\_

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## **SLEEPING**

We place the infants on his or her back in a crib or bassinet. Do you have any special ways of helping your child fall asleep? \_\_\_\_\_

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Does your child cry before going to sleep and how long? \_\_\_\_\_

Special toy or blanket for nap? \_\_\_\_\_

What is your child's present sleeping schedule? Nighttime? \_\_\_\_\_ to \_\_\_\_\_

AM Nap? \_\_\_\_\_ to \_\_\_\_\_

NOON Nap? \_\_\_\_\_ to \_\_\_\_\_

PM Nap? \_\_\_\_\_ to \_\_\_\_\_

## **TOILETING**

Is your child toilet trained? \_\_\_\_\_ Big toilet or potty chair? \_\_\_\_\_

What word does your child use for urination? \_\_\_\_\_ Bowel movement? \_\_\_\_\_

What age do you plan on toilet training your child if not yet trained? \_\_\_\_\_

How frequently does your child have a bowel movement? \_\_\_\_\_

Does your child frequently get diaper rashes? \_\_\_\_\_

## **HEALTH**

Does your child seem well most of the time? \_\_\_\_\_

Is your child currently taking medication? \_\_\_\_\_

If yes, explain? \_\_\_\_\_

How many ear infections has your child had in the last year? \_\_\_\_\_

Has your child had trouble with his/her vision? \_\_\_\_\_

How many weeks (gestation) was your child at the time of birth? \_\_\_\_\_

Explain if your child has ever been hospitalized \_\_\_\_\_

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Is their any health issues Tender Time should know about your child? \_\_\_\_\_

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Any known allergies or food restrictions? \_\_\_\_\_

What arrangements have you made for the care of your child should they become ill while at Tender Time? \_\_\_\_\_

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**Parent Signature** \_\_\_\_\_ **Date** \_\_\_\_\_