

Growing Together Family Resource Centre
Infant/Toddler/Preschool Information

Child's Name _____ Date _____

Relevant History (born premature, medical concerns, family dynamics, family customs you want the staff to be aware of and respect etc.) _____

Social and General

Does your child have any fears? (Dogs, sirens, loud noises) If yes, please explain; _____

What makes your child angry or upset? How does s/he express those feelings? _____

How do you comfort your child? _____

How do you reassure or reward your child? _____

Has your child been cared for by adults other than members of your family? _____

Has your child had any previous group experience? If yes, please explain: _____

How does your child relate to adults? _____

How does your child relate to other children? _____

Are there any other languages spoken in the home? _____

What's your child's favourite activity at home? (e.g. books, solitary play, playing with a parent, outdoors etc.) _____

Sleeping

Does your child nap? Yes No

Current napping schedule _____

Any concerns about rest time? _____

What time does your child go to bed in the evening? _____ Awaken? _____

What is your child's mood upon waking? _____

What does your child take to bed? (Teddy bear, blanket etc.) _____

Does your child talk or cry out during sleep? _____

Does your child use a pacifier Yes No

What word is used for naps or sleeping? _____

Please add additional information in regards to sleeping patterns for your child you would like us to know _____

Eating

Child's favourite foods: _____

Foods that are refused: _____

Any concerns about eating habits? _____

Infant/Toddler/Preschool Information

Infants

Bottles - Please describe your infant's current feeding and bottle schedule _____

How do you prepare your infant's bottle? _____

Is your baby's skin highly sensitive? Yes No

Does your baby get frequent diaper rashes? Yes No

Is diarrhea or constipation a concern? _____

How does your child go to sleep? (Rocked, in crib awake, music,) _____

Toddlers

Are bowel movements regular? Yes No How many per day? _____

Any concerns with diarrhea /constipation? _____

Has toilet training been attempted Yes No

Is your child trained for urine Yes No Bowel movements? Yes No

Can your child indicate the need to use the washroom? Yes No

What are the words used for urination? _____ Bowel movement? _____

Any particular words or expressions that may not be understood by the Early Childhood Educator _____

Please add any additional information you would like us to know. _____

Preschoolers

Are bowel movements regular? Yes No How many per day? _____

Any concerns with diarrhea /constipation? _____

Has toilet training been attempted? Yes No

Is your child able to use the toilet independently? E.g. remove clothing, clean him/herself, flush, wash hands etc.? Yes No _____

(Please comment on level of independence)

Can your child indicate the need to use the washroom? Yes No

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

Any concerns about toileting? _____

Please add any additional information you would like us to know.

Parent/ Guardian (signature) _____ Date: _____