What You Need To Know About My Child

*Completed by parent on each child and passed onto the Caregiver.

Name of child? _________________________________________________________________

Do you have a Nickname for your child? _________________________________________

Any name he/she DOES NOT like to go by _________________________________________

How do you prefer your child address the caregivers? Examples (Mrs. …. , Mamma…. by first name, Aunt….?) ___________________________________________________________

Is there a nightly routine (such as normal time for bed, bedtime reading, and prayers, special stuffed animal, blanket, music, night light etc)

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Does your child sleep through the night? Yes_____ NO_____ If not what is the best way to help him/her. __________________________________________________________________

Does your child wet the bed? ______ If yes, how is this handled?

______________________________________________________________________________

Any fears? ___________________________________________________________________

How do you provide your child comfort? _________________________________________

Any special toys or games your child likes to play? _________________________________

Any specific foods that your child likes? _________________________________________

What does a normal breakfast, lunch and dinner consist of? _________________________

______________________________________________________________________________
______________________________________________________________________________

Any meal time routines or chores (prayer before meal? Setting table, TV during meals etc)

______________________________________________________________________________

______________________________________________________________________________

Any food allergies? _____________________________________________________________

Any foods your child will not eat? _________________________________________________

Does your child have any special names for their body parts? _________________________
What does your child weekend routine look like? _______________________________________
______________________________________________________________________________

My child attends ____________________________ religious services.

My child’s doctor is __________________________ His phone number and or address is ____________________________ Next medical appointment is ____________________________
My child takes ____________________________ medication for ____________________________

Does your child have any immediate or ongoing medical needs we should be aware of?
______________________________________________________________________________

What is your child favorite game? ____________________________

Favorite Sport? ____________________________

Favorite TV program? ____________________________

Are there any friends or extended family members you would like for them to keep in contact with? Include relationship, name and contact information.
______________________________________________________________________________

Does he/she have a pet at home? _______If yes, what kind? _______Name? _____________

Does your child have any fear animals? Yes ____NO ____What Kind of Animal ________

Anything else you think we should know about your child to make him/her feel more safe and secure?
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________