

## Getting to Know Your Preschooler...

Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_

### Meal Time

Does your child have any known allergies?    **YES**    **NO**    Known allergies \_\_\_\_\_  
I will provide food for my child everyday                      **YES**    **NO**  
I will use the food provided by Growing Generations                      **YES**    **NO**

**Information we should know about meal time at home:** \_\_\_\_\_

Please list any table food your child CAN NOT have or if your child has any dietary restrictions:

\_\_\_\_\_

Special Instructions for feedings:

\_\_\_\_\_

### Sleeping:

What is your child's current sleeping schedule?

\_\_\_\_\_

Tell me about your child's sleeping habits: \_\_\_\_\_

Does your child nap?    \_\_\_ Yes            \_\_\_ No            If yes, how often: \_\_\_\_\_

### Toileting/ Diapering:

My child is toilet trained (please circle):                      **YES**                      **NO**  
How does your child indicate a need to use the toilet?  
    \_\_\_ goes on his/her own  
    \_\_\_ needs an adult to take him/her to toilet (how often?) \_\_\_\_\_  
    \_\_\_ tells adult he/she needs to use toilet (with what words?) \_\_\_\_\_  
How often does your child have an accident? \_\_\_\_\_

My child uses this brand of Diapers: \_\_\_\_\_ Size: \_\_\_\_\_

My child uses this diaper ointment: \_\_\_\_\_

Special instructions for diapering/toileting:

\_\_\_\_\_

### Developmental History:

Has your child been away from you before?    \_\_\_ Yes    \_\_\_ No    How Frequently? \_\_\_\_\_

Has your child been in group care before?    \_\_\_ Yes    \_\_\_ No    If yes, explain \_\_\_\_\_

How does your child handle separation from parent?    \_\_\_ without upset    \_\_\_ Briefly/mildly upset

Is your child easily frightened? ?    \_\_\_ Yes    \_\_\_ No    If yes, explain \_\_\_\_\_

How do you comfort your child? \_\_\_\_\_

Emotional Behavior (please indicate all that apply):

\_\_\_ Happy    \_\_\_ Calm    \_\_\_ Active    \_\_\_ Cheerful    \_\_\_ Stubborn    \_\_\_ Cooperative

\_\_\_ Quiet    \_\_\_ Independent    \_\_\_ Crying

How does your child display anger? \_\_\_\_\_

What behavior do you find most difficult to deal with and how do you handle it?  
\_\_\_\_\_

What disciplines are most effective with your child? \_\_\_\_\_

What methods should we use to comfort your child? \_\_\_\_\_

What fears does your child have? \_\_\_\_\_

Does your child have a particular comfort toy? \_\_\_\_\_

**Academic and Social Skills:**

Social behaviors (please indicate all that apply)

- Outgoing       Afraid of new people       Shy       Loud       Quiet       Adaptable  
 Worries       Easy going       Meets new people easily       Adjusts slowly  
 Adjusts quickly       Aggressive       Gives in easily       Stands up for him/herself

Is your child:  left-handed       right-handed       no preference yet

Please indicate which of the following your child can do:

- print first name       print last name       recite parents first names       tie shoes  
 recite street address       recite name of hometown       count to: \_\_\_\_\_  
 Recite telephone number       read

Does your child have any learning or behavior problems that require special attention? \_\_\_\_\_

If yes, explain and indicate how this is being handled now: \_\_\_\_\_

What will Growing Generations staff need to do to help? \_\_\_\_\_

Additional information we should know about your child? \_\_\_\_\_

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

