KINDER VILLAGE
An Intergenerational Child Care Center

GETTING TO KNOW YOUR INFANT/TODDLER QUESTIONNAIRE

This questionnaire is designed to help us become more familiar with your child in order to serve them better. The more a teacher understands about their students, the more sensitive they are to their needs. A copy of this form will go to your child's teacher. All questions on this form are confidential.

GENERAL

Child's name: _____ Date of birth: _____Current Age: _____

FAMILY

Mother's name: _____ Occupation: _____

Father's name: _____ Occupation: _____

Marital status of parents: _____ Are both parent's living at home? _____

Custody/living arrangements: _____

Has there been a divorce, death, or illness that may affect your child? _____

If yes, please circle which and describe briefly: _____

_____

HEALTH

Does your child have any medical conditions (asthma, diabetes, seizures)? _____

Does your child take any medication for those conditions? _____

Does your child have any frequent colds, earaches, fever, sore throat, stomachaches, vision problems or skin rashes?_____

EATING HABITS

Any food allergies? _____ Special diet? _____

Formula: _____ Breast Milk: _____ Have solids been introduced: Yes / No

Favorite foods: _____

Refused foods: _____

Child eats: on lap in high chair other: _____

Child eats with: spoon fork hands other: _____

TOILETING/DIAPERING HABITS

Is there frequent diaper rash? Yes / No

Do you use: oil powder lotion other:

Does child wear: disposable diapers cloth diapers

Are bowel movements? Yes / No how often: _____

Is there a problem with: diarrhea constipation

Is your child toilet trained: Yes / No If yes, when did you begin? _____

____ urination _____ bowels or _____ both

What is used at home: potty-chair special seat regular seat

Word used for urination: _____ bowel movement: _____

Does your child have accidents? Yes / No If yes, how often/when?_____

_____

SLEEPING HABITS

Does child sleep in: crib bed with parents

Does child sleep on: back side stomach

Swaddled? Yes / No Sleep Sack? Yes / No

Times child take naps? Times: a.m. _____/_____ p.m_____/_____

What does child take to bed? _____ mood on awakening_____

What time does child go to bed at night: _____awake in morning: _____

Are there any sleep/wake time rituals? If so, please describe._____

_____

_____

DEVELOPMENTAL HISTORY

Age child began sitting: _____ crawling _____ walking _____ talking _____

Does child: ____ pull up ____ crawl ____ walk with support

Times child is fussy: _____

How do you handle these fussy times? _____

How does your child communicate his/her needs? _____

_____

SOCIAL (For Toddler's only)

Do you see your child as: (Please circle the following)

Leader / Follower

Independent / Dependent

Shy / Confident

Easily distracted: Y / N

Self-control: Y / N

DAILY SCHEDULE

Please describe by approximate time your child's current daily activities (e.g., awakening, eating, time out of crib, napping, toilet habits, fussy time, bedtime):

MORNING AFTERNOON

_____

_____

_____

_____

Do you have concerns about your child's development or behavior?

What is the most important thing I need to know about your child?

What do you hope will be included in your child's preschool program?

THANK YOU FOR TAKING YOUR TIME TO COMPLETE THIS QUESTIONNAIRE!