

About Your Child

1. Child's Name/Nickname: _____ Today's Date: _____

2. What FOODS does your child especially like? _____

3. Especially DISLIKE? _____

4. Favorite toys, games, activities? _____

5. Is your child TOILET TRAINED? _____ What words does your child use for toilet? _____

6. How does your child express ANGER or frustration? _____

7. Does your child have any special FEARS? _____

Explain _____

8. When your child is upset, what helps to COMFORT him/her? _____

9. How do you DISCIPLINE your child? _____

10. Has your child been taking an afternoon NAP? _____ If so, how long? _____

11. If not, why? _____

12. Special toy or blanket for NAP? _____

13. Special FAMILY situations? (*Such as custody specifications, problems arising from situations, etc.*) _____

14. Anticipated ADJUSTMENT problems? _____

15. Any disorders/developmental (slow, advanced) diagnosed or suspected? _____

16. Previous childcare child has attended: _____

17. Any problems at previous daycares? _____

18. EXPECTATIONS of M & M Daycare _____

19. Other COMMENTS? _____

Health History

1. Child's name _____ Birth date _____

2. Illnesses: *(please check)*

Does your child have any problems with any of these?

- Asthma
- Constipation
- Convulsions
- Diabetes
- Diarrhea
- Fainting Spells
- Frequent Colds
- Frequent Ear Infections
- Frequent Sore Throats
- Heart Trouble
- Skin Rash
- Soiling
- Stomach Upsets
- Urinary Problem

Has your child had any of these diseases?

- Bronchitis
- Chicken Pox
- Hepatitis
- Lice
- Measles
- Mumps
- German Measles
- Polio
- Ringworm
- Scarlet Fever
- Tuberculosis
- Whooping Cough
- Worms
- Impetigo

3. Other ILLNESSES? *(besides above)* _____

4. Has your child been HOSPITALIZED? *(explain)* _____

5. Has your child had INJURIES with fractures or loss of consciousness? *(explain)* _____

6. Last VISION Test Date _____ HEARING Test _____ DENTIST Visit _____

7. Any other members of your family with SERIOUS ILLNESS recently? _____

8. Any other members of your family history of: ASTHMA _____ DIABETES _____ EPILEPSY _____

9. Other Concerns? _____

Referral Sources (Please check one or more)

- | | | |
|---|---|---|
| <input type="checkbox"/> Drive-by Sign | <input type="checkbox"/> Flyer | <input type="checkbox"/> Newspaper |
| <input type="checkbox"/> 4 C's Referral (Wayne Co.) | <input type="checkbox"/> CCN Referral (Washtenaw Co.) | <input type="checkbox"/> Belleville Chamber of Commerce |
| <input type="checkbox"/> Belleville Schools | <input type="checkbox"/> Parental Referral | <input type="checkbox"/> Daycare Referral |
| <input type="checkbox"/> Other _____ | & Name Parent _____ | & Name Daycare: _____ |