INTAKE SHEET

1. Child's Identification Information

Name: _____ Nickname: _____

Address: _____ Phone Number: _____

Sex M F Birth date: _____Grade or Room: _____

2. Family Information: Parents or Guardians

Name Address Place of employment Work Phone

_____

_____

_____Single _____Married _____Divorced _____Separated _____Foster Parent

Names and ages of other children in the home:

_____ _____

_____ _____

3. Child's Medical History

Allergies (food, medication, bees, etc.)_____

Chronic, recurrent illnesses, or diseases (asthma, seizures, diabetes etc.) _____

Does your child take medication for this condition? ____yes ____no

If yes, please state the name and dosage: _____

Will the medication need to be given during program hours? ____yes ____no

If yes, when and how is it to be given? _____

What should we do if your child has a problem related to his/her medical condition during program hours?

_____

4. Play and Sociability

How does your child get along with other children? _____

His/Her usual playmates are_____girls_____boys_____older_____younger

What is the usual size of your neighbor playgroup? _____

Previous Group experience other than school: _____Preschool_____Playgroup_____Sunday school

5. Personality and Emotional Development

Is your child affectionate? _____To whom? _____

Does your child accept new people easily? _____yes _____no

What are your child's fears? _____

Is your child usually happy? _____yes _____no

What nervous habits does your child have? _____

Is your child's feelings hurt easily? _____yes _____no

6. Discipline

When you find it necessary to discipline your child, which parent usually does it and how?

_____

Infants and Toddlers

Has your baby had any feeding problems? _____yes_____no
If yes please explain_____

Have you noticed any allergies or sensitivities to particular foods? _____

Is your baby: _____breast feed_____bottle feed

What food is your baby eating now?
Fruits_____ Juices_____ Vegetables_____ Meats_____
Cereals_____ Milk (formula)_____

What are your child's sleep habits_____

Does your child have a "fussy" time? When? _____

How do you handle this "fussy" time? _____

Does your baby prefer to sleep on their _____back _____stomach

Do you have special ways of helping your baby go to sleep? _____
If yes, how? _____

Does your child use a pacifier or suck thumb/fingers? _____

Has toilet training been attempted? _____yes _____no What is used at home? _____

Is your baby's skin highly sensitive? _____yes _____no What is used at home? _____

How does your child relate to strangers? _____

Is your child frightened by anything? _____

Other Information: Please list some of your child's favorites

Snacks and drinks_____

Games and Activities_____

Give any further information that would be helpful in understanding your child or would enhance your child's experience in our program. _____
_____