## Infant Care Questionnaire

DIS	COV	ERY		
		NCTI	ONING	Î
400	00	0.0	CENTE	7

Child's Name:		Date of Birth: ———	CHILD DEVELOPMENT CENTER	
Sibling: Sibling: Sibling: Sibling:		Age:	<ol> <li>Does your child hold his/her own.</li> <li>Leave your child hold his/her own.</li> </ol>	
		Age:		
				NAPPING ROUTIN
1. <u>NAPS</u>	TIME	<u>LENGTH</u>	FOOD IMFORMATION:	
		A separation COS DS		
2. Describe your child				
3. Does your child sleep	p with a	Conites de la s	<ol> <li>D. se general billet delait from a cent</li> <li>What atomille does your child as</li> </ol>	
		BlanketYES NO	→PacifierYES NO	
PHYSICAL DEVEL	LOPMENT:	DN SEV Venglebr	Foods Sold (2nd any Teeding p	
1. Can your child				
⇒Sit supported	YES NO	⇒Sit aloneY	ES NO	
→ Walk support <b>DIAPERING INFO</b>		→Walk alone	.YES NO	
1. What lotions, pow	vder or ointments will you	u supply for us to use on your	child for wet diapers, bowel	
	information that you feel	may be helpful in making yo	ur child feel more secure and	
FEEDING ROUTIN	E:			
Time		Kind of Food	<u>Portions</u>	
1				
2 3.			a A Ba <del>lline de la journal de</del> la A	
			<del>a send endominale duce la c</del> roite	

				2
<b>BOTTLE INFORMATION:</b>				Telar
1. Is you child breastfed?	YES	NO		
2. Is your child familiar with a bottle?	YES	NO		
3. Does your child hold his/her own bottle?	YES	NO		
4. Does your child take his/her bottle warmed?	YES	NO		
5. Your child normally drinks ounces at or	ne feeding.			
6. Your child normally burps after ounces.				
7. Your child drinks what types of liquid (circle)	Formula	Milk J	luice Wat	er mailaid
8. If your child is sleeping, would you like for us to w	vake them for	or their bottle?	YES N	O
FOOD IMFORMATION:				
1. Does your child eat				
⇒Strained baby foodYES NO	→Finger	foodsYES	NO	
→Junior foodsYES NO	<b>→</b> Table f	oodsYES	NO	
2. Does your child feed him/herself? YES NO				
3. Does your child drink from a cup? YES (Alc	one or V	Vith help)	ON	
4. What utensils does your child use when eating? _			selliwa	l. Does your child slee
5. Please check $\blacksquare$ the appropriate items in regards to	your child's	s eating habits.		
⇒Baby Food ⇒Formula ⇒Bre	ast-Fed	Finger	Food	→ Table Food
→ Feeds Self →Uses Spoon →Use	es Fork	_ → Uses C	Cup	
6. Has your child had any feeding problems? YES	NO			
*If yes, what are they?		~		. Can your child
7. Does your baby have a good appetite and show inter-	rest in food?	YES NO		⇒Sit supported
8. Does your child have any favorite foods?		OM	837bit	w Walk strepor
9. Are there any foods your child dislikes?		***	MONTANA	DAPERING INFO
10. Does your child have any food allergies?	the state of	Love like orang	rinto no sobr	og znoltot salW
11. In what way does your child let you know when he	e/she is finis	hed eating?		
ADDITIONAL INFORMATION:				
Any other information you would like use to know about	ut your chil	d?		
			*****	
Special Instructions:				
	In Levi M			THE REPORT OF THE PROPERTY OF
0.07	M. Mail Mal		***************************************	SEPERAL .
A family masting is afford 45 days 6.	11	TI.:	1	
A family meeting is offered 45 days after your child's of action and goals, the teachers have set for your shild.				
ation and goals the teachers have set for your child Pleachers after your child has been enrolled here at Disc			i like a meeti	ng with your child's
teachers after your child has been enrolled here at Disc Parent's Signature:	overy Juncti	ion for 45 days		

## Toddler Child/Parent Orientation

Measles

Mumps

I. I JUNCTION Child's Name \_\_\_\_\_ Age of Child\_\_\_\_\_ CHILD DEVELOPMENT CENTER Parent's Name Start Date Parent's Address and Telephone Number In order for the staff here at Discovery Junction to provide quality care to you and your child, we would like to ask you a few questions regarding his/her developmental history and family background. Family Background \* Are there any others living in the house? \* Are there any family members that are serving in a branch of military? \* What is your families cultural background? \_ \* Would you be interested in sharing information about your cultural throughout the year during special times recognized by your culture? \* What is your families ethnical background \* Would you be interested in sharing ethnical information about your family throughout the year during special times recognized by your ethnicity? \* What are some hobbies that mom/dad are interested in? \* If there were times where we need some assistance around the center would you be willing to help out? Child's Health: \* Does your child suffer from allergies? \_\_\_\_ yes \_\_\_\_no
If yes, please explain what allergies:

\* Does your child take medication for his/her allergies? \_\_\_\_ yes \_\_\_\_no \* Is there anything we should know about your child's physical or mental health? If yes, please elaborate: \* Has your child ever been hospitalized outside the normal? \_\_\_\_yes \_\_\_\_ no If yes, explain: \* Has your child started to demonstrate large muscle use and movement? If so what are they doing? \* Has your child started to demonstrate fine motor use and movement? If so what are they doing? \* Has your child experience any traumatic experiences? Does your child have problems with or had any of the following: (circle all that apply) Constipation Diarrhea Fainting Spells Frequent Colds Skin Rash Ring Worm Tuberculosis Stomach Upsets Whopping Cough Polio Ear Infections Sore Throats Bronchitis Diabetes Hepatitis Asthma Chicken Pox

**Impetigo** 

Sleeping Habits
* Does your child prefer to sleep on his/her back or stomach?  * Does your child have a favorite toy to sleep with?  * What kind of atmosphere does your child normally sleep in?  * How often is your child sleeping right now?  * Does your child use a pacifier at nap time?  * Does your child wear a diaper or pull- up at nap time?
* Is your child using words? Does your child speak in sentences?*  * Has your child had previous exposure to other children?yesno  * Does your child experience separation anxiety?yesno  If yes, what is best in assisting?
* Does your child have trouble adjusting to change?yes no If yes, how do you assist?
* When your child is upset, how do you comfort them?
* How does your child express anger/frustration? * Is there anything you are concerned about with your child's social development?
* Is there another language spoken in your house that may be a language barrier between your child and another? What language?
* Likes Dislikes Dislikes
* How often does your child eat ?  * When being fed, how does our child prefer to be held?  * Has your child began holding his/her own bottle?
<u>Miscellaneous Information</u>
Plas your child experience any travinatic experiences?
A family meeting is offered 45 days after your child's enrollment. This meeting is to share with you the 45 day evaluation and goals the teachers have set for your child Please sign below if you would like a meeting with your
child's teachers after your child has been enrolled here at Discovery Junction for 45 days

Date:

Parent's Signature: \_\_

## <u>Preschool & School-Age Child/Parent</u> <u>Orientation</u>



Child's Name	· Ya	our child normally sleep	CHILD DEVELOPMENT CENT
Parent's Name			Start Date
In order for the s	taff here at Discovery	Junction to must de	y care to you and your child, we would history and family background.
* Are there any	kground others living in the		
* What is your f * Would you be special times red	amilies cultural back	ground? g information about you	r cultural throughout the year during
during special tin  * What are some  * If there were t	interested in sharing nes recognized by y hobbies that mom	g ethnical information all our ethnicity? /dad are interested in?	oout your family throughout the year and the center would you be willing to
* Does your child * Does your child If yes, ple * Does your child * Is there anythi	th:  d suffer from allergie ase explain what all d take medication fo	es? yesno ergies: r his/her allergies? about your child's physi	yesno cal or mental health?
* Has your child If yes, exp	ever been hospitaliz plain:	ed outside the normal?	yes no
* Has your child	started to demonstr	ate large muscle use an ate fine motor use and i matic experiences?	d movement?
Does your child Constipation Skin Rash Sore Throats Asthma Measles	have problems we Diarrhea Ring Worm Ear Infections Bronchitis Mumps	rith or had any of the Fainting Spells Tuberculosis Whopping Cough Diabetes Hepatitis	following: (circle all that apply) Frequent Colds Lice Stomach Upsets Polio Chicken Pox Impetigo

## Sleeping Habits \* Does your child prefer to sleep on his/her back or stomach?\_\_\_\_\_\_ \* Does your child have a favorite toy to sleep with? \* What kind of atmosphere does your child normally sleep in? \_\_\_\_\_ \* How often is your child sleeping right now? \_\_\_ \* Does your child use a pacifier at nap time ? \_ \* Does your child wear a diaper or pull- up at nap time? Social Development \* Has your child had previous exposure to other children? \_\_\_yes \_\_\_no \* Does your child experience separation anxiety? \_\_\_yes \_\_\_no If yes, what is best in assisting? \* Does your child have trouble adjusting to change? \_\_\_\_yes \_\_\_\_ no If yes, how do you assist? \* When your child is upset, how do you comfort them? \_\_\_\_\_ \* How does your child express anger/frustration? \* Is there anything you are concerned about with your child's social development? \* Is there another language spoken in your house that may be a language barrier between your child and another? \_\_\_\_\_ What language? \_\_\_\_ Foods Dislikes \_\_\_\_\_ \* Likes \* How often does your child eat ? \_\_\_\_\_ \* What would you like us to do if your child refuses to eat? \_\_\_\_\_ Miscellaneous Information

	Spraph veril era deniv oa a
A family meeting is offered 45 days after your child's	enrollment. This meeting is to share with you the 45 day eval-
uation and goals the teachers have set for your child child's teachers after your child has been enrolled here	Please sign below if you would like a meeting with your
Parent's Signature:	Date: