INFANT/TODDLER (BIRTH TO 36 MONTHS) DEVELOPMENT & ROUTINE

We want to provide your child with the best care possible. Please help us to get to know your child by filling out this questionnaire. Thank you!

Child’s Name ___________________________ Date of Birth ___________________________
Facility ___________________________ Room ___________________________

DAILY Routines

SLEEPING
• Please describe your child’s usual bedtime routine (including what time and where he/she usually sleeps). __________________________________________________________
• How do you know that your child is sleepy/tired? __________________________________________________________
• Does your child have any difficulties falling asleep? _______ If yes, what is helpful? ____________________________________________
• About how many hours of uninterrupted sleep does your child get each night? ____________________________
• How many times per day does your child nap? _______ How many hours on average? ____________________________
• Does your child sleep with a special blanket, toy, pacifier, song? ____________________________________________
• Do you have any concerns about your child’s sleep habits? _______ If yes, please explain: ____________________________

EATING
• Does your child generally enjoy eating? _______ Do you consider your child a good eater? ____________________________
• What are some of your child’s favorite foods (temperatures, textures, etc.)? ____________________________
• Is your child on any special diet? __________________________________________________________
• If your child has any food allergies, please list here: ____________________________________________
  ☐ If child has food allergies, ensure a Feeding and Nutrition Care Plan is established and on file.
• Are there any other foods you do not want us to offer your child? ____________________________________________
• Are there foods from your home/culture that you would like us to offer? ____________________________________________
• Do you breastfeed your child? ☐ Yes ☐ No If yes, how often? ____________________________________________
• What does your child eat with? ☐ hands ☐ spoon ☐ fork Does your child eat independently? ☐ Yes ☐ No
• What does your child use to drink? ☐ bottle (type of nipple: _____________) ☐ tippy cup ☐ regular cup
• Do you have any concerns or questions about your child’s eating habits? _______ If yes, please explain: ____________________________

TOILETING
• Does your child wear diapers? _______ If yes, what kind? ☐ disposable ☐ cloth ☐ Pull-ups For naps? ____________________________
  If no, does your child use the toilet regularly? _______ Please explain: ____________________________
• Families use a variety of words to describe bathroom activities. Indicate the words your family uses for:
  urine ____________________________ bowel movement ____________________________ genital area ____________________________
• Do you have any questions or concerns about your child’s toileting habits? _______ If yes, please explain: ____________________________

PLAY
• Does your child have a favorite toy/object or song? ____________________________________________
• Does your child enjoy playing with others? _______ Does your child enjoy playing alone? ____________________________
• What activities and/or toys does your child enjoy? ____________________________________________
HEALTH

• Does your child have any health problems? ______ If yes, please explain: ________________________________

• Is your child taking any medication(s) regularly? ______ If yes, please list: ________________________________

○ If medications are to be given while in care, ensure a Medication Administration Form is utilized and on file for your child.

• Does your child have a chronic health condition or specific health needs? (please be specific) ________________________________

○ If yes, ensure a Special Health Care Plan is established and on file for your child.

• Does your child have frequent ear infections? ___________ diarrhea? ________________________________

• Do you have any concerns about your child’s health? ______ If yes, please explain: ________________________________

Children in group care may become ill with colds, viruses, etc. several times per year. At times, we are required to ask parents to keep their children out of child care until treatment begins or there are no symptoms. Please see our Exclusion policy.

GENERAL DEVELOPMENT

• Do you have any concerns about your child’s:
  ▪ hearing and/or vision? ________________________________
  ▪ speech and language development? ________________________________
  ▪ ability to move? ________________________________
  ▪ overall development? ________________________________

• What languages are spoken at home? ________________________________

• What is your family’s cultural identification (values, traditions)? ________________________________

SOCIAL AND EMOTIONAL DEVELOPMENT

• Has your child ever been in group care? ☐ Yes ☐ No If yes, how many different settings? ________________________________

• How does your child respond in group situations? ________________________________

• What can we do to help your child adjust to child care? ________________________________

• How would you describe your child’s temperament? ________________________________

• How does your child communicate his/her needs? ________________________________

• How do you comfort your child? ________________________________

• Does your child use a special comforting item (such as a blanket, stuffed animal, doll)? ________________________________

• Does your child fear certain things? ________________________________

• How is your child disciplined? ________________________________

• What works best when you discipline your child? ________________________________

• Do you have any concerns about your child’s social-emotional development or behavior? ______ If yes, please explain: ________________________________

• What educational/developmental experiences would you like us to emphasize with your child (for example, language development, social relationships, kindergarten readiness skills, physical or self-help skills, etc.)? ________________________________

Parent’s Signature: ________________________________ Date: ________________________________