Presbyterian Weekday School

Child Profile

Introduce us to your child!

Infant-Toddler Program

DATE: _____ Assigned Class: _____
Last Name: _____ First Name: _____ Middle: _____
Name to be used in class: _____
Siblings (names and ages): _____

SOCIAL

Child's previous infant/toddler care experience (where, number of years): _____
_____

What opportunities does your child have to interact with others the same age: _____
_____

If child is mobile, what strategies of discipline /guidance are used with your child?_____
_____

Has your child experienced any recent stresses (i.e., new sibling, leaving home, death of relative or friend, separation or divorce, move to a new home, new pet or death of pet): _____
_____

If so, how has the child reacted to this stress? _____
_____

What methods do you use to soothe/console him or her?_____
_____

HEALTH

Eating Patterns:

- Are there any dietary concerns/dislikes? _____
- Are there any food allergies? _____
- Special instructions:_____
- What are your child's eating habits? (Times child usually eats, mind trying new things, etc.)_____
- If your child is drinking formula, do they prefer it cold or warm?_____
- Child's usual dining habits (circle those applicable); High chair, table, uses utensils, bottle, sipper cup, regular cups.
- Does your child have a small or large appetite?_____
- What are your child's favorite foods? _____

Sleeping Patterns:

- Bedtime is at: _____ Arise at: _____
- Naptime: _____ How long? _____
- Does your child have any sleep problems? Yes ( ) No ( ). If yes, describe_____
- If infant, how do you prefer your infant to be placed in the crib (front, back, side). Please circle one.
- What is their disposition when waking up? i.e. happy, grouchy, clings, slow?_____

Eliminating Patterns

- Toilet trained yet? _____ Yes _____ No
- Does your child need reminding? _____ Yes _____ No
- If yes, at what time intervals do you suggest? _____
- Does your child have certain words to indicate a need to eliminate? _____
  _____

Health Patterns:

- List any allergy alerts _____
- List any regular medications, intervals _____
- List any special needs or outside support services that s/he receives (i.e. speech therapy, occupational therapy, physical therapy). Identify type of service, frequency and provider
  _____
  _____

Personality Traits: (Circle all that apply)

Shy/Reserved	Restless	Outgoing/curious
Standoffish/observer	Sensitive/frightens easily	Demonstrative
Cuddly	Active	Cautious

Warms slowly to new people, situations

Identify child's favorite toys, activities._____
_____

Please list any concerns you may have about your child's development (i.e., social skills, gross motor or fine motor skills, language, cognitive) _____
_____
_____
_____

Is there any other information we should know in order to help us get to know your child better?
_____
_____
_____
_____
_____

Please indicate what you hope (your goal) your child will gain from his or her infant/toddler experience this year: _____
_____
_____
_____
_____
_____

_____

Parent/Guardian completing form

***NOTE: The office must have on file your child's current up-to-date immunizations prior to program entrance.**