Getting to Know Your Baby

Your child is very important to us and we would like you to help us get to know him/her better. The following information will assist us in providing the best care for your child. Please complete this form and return it to the office.

Child's Name	Birthdate	Address	Home Phone

Health:

Any Allergies?	Frequent Colds?	Frequent Stomach Aches	Special Instructions if child becomes ill

Social Relationships:
Previous group experience_____

By nature, is child (please mark all that apply with an "x"

Friendly	Aggressive	Shy	Withdrawn

How does he/she get along with siblings?_____
Knows the following children in our school:_____
Favorite toys and activities at home:_____

Comments:
In what particular way can we help your child this year? What do you hope your child will gain from this experience?
_____
_____
_____

Eating:
Average spand between bottles?_____hours. Drinks approximately_____ozs.
Any snacks between meals?_____
On table food _____Baby food_____
What stage?_____
Favorite Foods _____
Food Dislikes _____
Food Allergies _____

Sleeping:
Time child goes to bed in P.M.? _____ Awakens in A.M.? _____
Does child have own room?_____ Mood when awakened_____
Average time and duration of naps A.M._____P.M._____
Sleeps on back? ____Stomach?____ Side?_____
Additional Comments or Information:
_____
_____
_____
_____
_____
_____
_____