Little Village Home Child Care LLC

Toddler History

Today's Date _____

Child's Full Name _____

Date of Birth _____

Gender: M F

Health

1. Is your child currently taking any medications? Yes No If yes,

Name of Medication: _____

Reason for Medication: _____

2. Does your child have any special needs or disabilities? Yes No If yes, please describe:

_____

_____

_____

3. Has your child had any of the following? (Please Circle.)

Premature birth Trouble breathing at birth

Birth injury/Defect Head Injury Convulsions/Seizures

Allergies

_____

_____

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Development

4. How is your child best comforted?

_____

_____

5. What are your child's favorite toys?

_____

6. What is your child's Sleeping Pattern: Please describe any specific ways in which you help your child to fall asleep:

_____

7. What is your child's current sleeping schedule?

Morning Nap: Begin _____ End _____

Afternoon Nap: Begin _____ End _____

Nighttime: Begin _____ End _____

Does your child use a special toy at naptime? Yes No

Does your child use a blanket at naptime? Yes No

Feeding

8. What is your child's present eating schedule?

Breakfast _____ Morning Snack _____

Lunch _____ Afternoon Snack _____

Food Likes:

_____

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Food Dislikes:

_____

Please list Food Allergies here: **PLEASE BE ADVISED FOOD ALLERGIES MUST HAVE SIGNED FORM BY THE STATE OF INDIANA FROM THE DOCTOR.**

_____

_____

Toileting

9. Does your child have diaper rash often? Yes No If so, how is it best treated?

_____

10. Is your child toilet trained? Yes No

What word does your child use for urination? _____

For a bowel movement? _____

Does your child use a potty chair? Yes No

Is your child able to remove his/her clothing unassisted? Yes No

Additional Information

_____

_____

_____

Signature of Parent: _____ Date: _____

Signature of Parent: _____ Date: _____

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