The Learning Connection child development center	**Children's Information**
	Child's File /Classroom

2 years & older

Child's name: _____ DOB: ___/___/___ Age: _____ Sex: _____

Has your child had previous childcare placement? ( ) Yes ( ) No

Where was your child enrolled? _____

Are any medications given regularly? ( ) Yes ( ) No

Who will take care of the child during illness? _____

What is your child's favorite food? _____

What food does your child dislike? _____

Is your child potty trained? ( ) Yes ( ) No

Can your child be relied upon to indicate bathroom wishes? ( ) Yes ( ) No

Does your child have any "accidents"? ( ) Yes ( ) No

What words does your child use for: urination: _____ bm's: _____

Does he/she sleep through the night? ( ) Yes ( ) No

Does your child take an afternoon nap? ( ) Yes ( ) No How long? _____

Special toy or blanket for naptime? ( ) Yes ( ) No What? _____

What sort of discipline works best for your child? _____

How does your child behave when sick? _____

How is your child most easily settled when upset? _____

What are your child's favorite activities, toys, books, or games? _____

By signing this form, you verify that all of the information provided is correct to the best of your knowledge.

Father/Guardian's Signature	Date
Mother/Guardian's Signature	Date