Child Assessment Form

Child Name (Last, First, Middle)	Enrollment Date	Date of Birth

Street Address (if rural, attach directions)	City	Zip

Mailing Address (if different) -- Street or P.O. Box	City	Zip

Home Telephone No. (Include A/C)	Cell Phone No. (Include A/C)

Mother's Occupation/Employer	Father's Occupation/Employer

Health:

Does your child have any allergies?	☐ Yes	☐ No
If so, what allergies does your child have?		
How should we respond if he/she has an allergic reaction?		
Does your child require an EpiPen?	☐ Yes	☐ No
Does your child have an existing illness?	☐ Yes	☐ No
If so, please list.		
Has your child had a previous serious illness or injury, or hospitalization during the past 12 months?	☐ Yes	☐ No
If so, please list.		
Is your child taking any medication?	☐ Yes	☐ No
If so, how is the medication administered, and will it need to be administered while he/she is in care?		
Is the medication prescribed for continuous use?	☐ Yes	☐ No
Are there any side effects we should be alerted to?	☐ Yes	☐ No
If so, please list.		

Toileting:

Does your child need assistance with toileting?	☐ Yes	☐ No
How can we best help?		
What are your ideas about toilet training?		
How can we best help?		

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Behavior:

Does your child have any special fears?	☐ Yes	☐ No
How does your child communicate his/her needs?		
Are there any special words that your child uses that might not be readily recognized?		
How do you tell your child to stop a behavior that you don't approve of or that might be dangerous?		
When your child gets upset, what helps him/her calm down?		
What is a good way to distract your child when he/she is having a temper tantrum?		
Are there any particular routines that are particularly helpful at naptime?		
What position is most comfortable for your child when he/she is napping?		

Eating Preferences:

What are your child's favorite foods?
Does your child use utensils, eat with fingers, feed self?
Does your child choke easily while eating?

Activities:

What activities do you like to do with your child?
What activities does your child like to do when playing with other children?
What does your child like to do when he/she is playing alone?

Family History:

Tell me about your family (i.e. child's parents, siblings, grandparents, and other extended family)

Additional Comments:

Signature of Parent

Date