Getting to Know Your Infant/Toddler
0-24 months

Child's Name: _____ Child's Date of Birth_____

Child Lives With:

Name: _____ Relationship to child: _____

Cell phone: _____Email address: _____

Name: _____ Relationship to child: _____

Cell phone: _____Email address: _____

Non-Custodial Parents:

Name: _____ Relationship to child: _____

Cell phone: _____Email address: _____

Name: _____ Relationship to child: _____

Cell phone: _____Email address: _____

Does the child see this person? _____ Will this person interact with your child at the Center? _____

Any restrictions/limitations (COPY OF LEGAL DOCUMENTS MUST BE FURNISHED):_____

Sibling's names & ages:

_____ _____

_____ _____

_____ _____

Health

Does your child seem well most of the time? Yes No

Child's General Mood: Are they mostly Happy, fussy, colicky, what?_____

Is your child taking any medications regularly (such as Tylenol, laxatives, vitamins, etc?) Yes No

If yes, what and when? _____

****Please note that BBP staff is not able to administer any medication****

How many ear infections has child had in the past year?

_____

Has your child ever been seen by a medical specialist? Yes No

If yes, explain: _____

Has your child had any other illnesses/diseases? Yes No

If yes, explain: _____

Has your child had any serious accidents, hospitalizations, etc.? Yes No

If yes, explain: _____

Has your child had any of the following (please explain all that you marked):

_____ Birth injury or defect: _____

_____ Seizures: _____

_____ Breathing problems: _____

_____Head injuries: _____

_____ Allergies, eczema, hives, drug/food intolerances, asthma/wheezing, insect stings:

_____

_____Other: _____

Developmental History:

Has child been away from you before: Yes No How frequently? _____

Has child been in a group before? Yes No If yes, explain: _____

How does child handle separation from parent? fine briefly/mildly upset very upset

Is your child easily frightened? Yes No If yes, explain: _____

How do you comfort your child? _____

Emotional Behavior (please indicate all that apply):

Happy Calm Active Nervous Excitable Cheerful Stubborn Crying

Cooperative Quiet Independent Wants Own Way Temper Tantrums Easily Angered

Does your child bite? Yes No

If yes, explain: _____

What are child's favorite toys & activities? _____

Potty Patterns:

How often does your child have a bowel movement?

_____

Is your child's average stool:

Very soft (like a newborn) soft firm (like an adult) very hard (pellet like)

Other information: _____

Additional information:

How would you like for us to help your child grow?

_____

_____

Comments:

_____

_____

_____

Thank you for helping us get to know your child!

Please fill out and return as soon as possible.