Children's Learning Center
905 S. 4th St.◆PO Box 531◆DeKalb, IL 60115◆Phone 815.756.3506◆Fax 815.756.3508◆www.clcdaycare.org

ALL ABOUT ME

This information will be kept in your child's classroom file as a reference for teachers and staff.

Child's Full Name: _____ Date of Birth: _____

Nickname (if any): _____ Language(s) spoken at home: _____

Parent/Guardian Full Name(s): _____

☐yes ☐no Has your child previously been enrolled in child care?

☐yes ☐no Has anyone other than parents had an important part in the care of your child? (who, when) _____

_____

☐yes ☐no Does your child spend time with other children? (names and ages) _____

_____

☐yes ☐no Are there any "family rules" you would like CLC to be aware of? _____

_____

☐yes ☐no Does your family celebrate holidays and birthdays or any cultural holidays or traditions?

_____

What do you hope your child will gain or learn at Children's Learning Center? _____

_____

What are your expectations of this program and the teachers? _____

_____

What was your child's weight at birth? _____ Was your child born at full term? _____

☐yes ☐no Did your child experience any problems at birth? _____

How does your child react to an elevated temperature? _____

What are some words you would use to describe your child's personality (circle)?

calm shy excitable happy sensitive loud
quiet active curious stubborn funny easily angered
other: _____

How would you describe your child's interactions with other children (circle)?

friendly aggressive physical affectionate helpful sensitive timid
other: _____

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

What are your child's strengths? _____

What kinds of discipline work best with your child? _____

_____

☐yes ☐no Does your child have any behaviors that concern you?

_____

☐yes ☐no Does your child have any fears that might arise while in our care?

_____

☐yes ☐no Has your child used computers or other technology?_____

☐yes ☐no Has child experienced any difficulty achieving developmental milestones (circle)?

sitting crawling walking naming simple objects repeating simple sentences

If yes, explain: _____

☐yes ☐no Has your child experienced any difficulty the following? speech vision hearing

If yes, explain: _____

☐yes ☐no Does your child have any chronic medical conditions or life-threatening allergies?

If yes, explain: _____

SLEEP / REST

☐yes ☐no Does your child sleep in his/her own bed? _____

☐yes ☐no Does your child sleep in his/her own room? _____

Who usually puts your child to bed at night? _____

What time does your child usually:

go to bed _____ wake up _____ nap _____ for how long _____

☐yes ☐no Does your child sleep with something special?_____

☐yes ☐no Does your child have any problems sleeping?_____

What is your child's disposition upon waking (circle)?

cheerful grouchy clingy sleepy other: _____

MEALS

☐yes ☐no Does your child enjoy mealtime? _____

☐yes ☐no Can your child eat without help? _____

What are some of your child's favorite foods? _____

What are some foods your child dislikes? _____

SELF CARE

☐yes ☐no Can your child dress/undress without help?_____

☐yes ☐no Is your child toilet trained?_____

☐yes ☐no Does your child need help going to the bathroom? _____

What word(s) does your child use for: urination? _____ bowel movement? _____

Please list any additional information or concerns you would like to share with CLC: _____

_____

_____

_____ _____ _____

Parent/guardian SIGNATURE Parent/guardian name PRINTED Date

Visit Date: _____ Parent/Guardian Initials: _____ Head Teacher Initials: _____