Learning Connections of Bartonville

TODDLER FACT SHEET

Child's Name ________________________________ Birthdate__________________

Primary Contact's Name ____

HEALTH

Does your child seem well most of the time? Yes___ No (explain)____________________________________

Does your child take any regular medications, vitamins, or laxatives? Yes _______________________ No ___

Are you concerned about your child's hearing? Yes _____ No _____

Are you concerned about your child's vision? Yes _____ No _____

Does your child have any disabilities? Yes ____ No ____

Has your child been hospitalized? Yes ____ No ____

Has your child had any of the following:

premature birth Yes ____ No ____

birth injury Yes ____ No ____

birth defects Yes ____ No ____

convulsions Yes ____ No ____

seizures Yes ____ No ____

asthma Yes ____ No ____

head injury Yes ____ No ____

Is your child's skin highly sensitive to anything? ____

Are there any other significant illnesses that we need to know about? ___________________________________
____

What arrangements have you made for the care of your child should he become ill at the center?
____

DEVELOPMENTAL HISTORY

How do you comfort your child? ____

What are your child's favorite toys? ____

What are your child's favorite activities? ____

Does your child have a "fussy" time? Yes _____ No _____ When?____________________________________

How do you handle such time(s)? ____

Does your child use a pacifier? Yes _____ No _____

Does your child suck his thumb? Yes _____ No _____

How has your child been affected by teething? ____

SLEEPING

Do you have any special ways of helping your child get to sleep? _____________________________________
____

What is your child's present sleeping schedule?

Morning Nap from___________to__________________

Afternoon Nap from___________to__________________

Night Time from___________to__________________

FEEDING

Breakfast____
Lunch____
Snacks____
Dinner____
Does your child handle a cup or spoon? ____
Does your child eat in a high chair? Yes _____ No _____
Does your child eat at a table? Yes _____ No _____

Are there any other significant feeding issues that we need to know about? ______________________________
____

TOILETING
Has toilet training been attempted? Yes _____ No _____
If yes, what is used at home? potty chair ________ special toilet seat ________ regular toilet seat _________
"pull-ups" ________ training pants ________
How frequently does your child have a bowel movement? ____
What time of the day? ____
Is diarrhea _____or constipation _____a problem?
If so how do you treat it? ____
Is diaper rash a problem? Yes _____ No _____
If so how do you treat it? ____

OTHER INFORMATION
Does your child have any specific comfort items? ____
____

What are your child's favorite toys and/or activities? ____
____

Does your child have special words/names for objects and/or people? ________________________________
____
____

Are there any other facts that we should know about your child?_______________________________________
____
____

Thank you for taking time to complete this form. It will be used in planning to meet your child's needs.