

RECTORY SCHOOL

Children At Rectory

INFANT • TODDLER • PRESCHOOL

CARe Parent and Child Information Sheet

Child's Name: _____ Date of Birth: ____/____/____
Nickname to which child responds: _____ Home Tel. #: _____
Home Address: _____

Parent/Guardian Name: _____ Occupation: _____
Place of Employment: _____
Home Address: _____ Home Tel. #: _____
Work Address: _____ Work Tel. #: _____
Cell Tel. #: _____ Email: _____

Parent/Guardian Name: _____ Occupation: _____
Place of Employment: _____
Home Address: _____ Home Tel. #: _____
Work Address: _____ Work Tel. #: _____
Cell Tel #: _____ Email: _____

OTHERS LIVING IN THE HOME:

Name: _____ Age: _____ Relationship to Child: _____

Name: _____ Age: _____ Relationship to Child: _____

Name: _____ Age: _____ Relationship to Child: _____

Name: _____ Age: _____ Relationship to Child: _____

INTERESTS

What are your child's favorite toys? _____

What are your child's favorite activities? _____

Is there any other information about your child - special interests and/or fears; or ways that you give care - that would be helpful for our teachers to know in order to take better care of your child? Please tell us...

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FEEDING

Does your child have any allergies (food, medication, other?) No _____ Yes _____

If "Yes", which
foods? _____

Has your child had any feeding problems? No _____ Yes _____

If "Yes", describe: _____

Can your child eat with a spoon? No _____ Yes _____

Can your child eat with a fork? No _____ Yes _____

Can your child cut with a plastic knife? No _____ Yes _____

Does your child have a good appetite? No _____ Yes _____

What are your child's favorite foods? _____

What foods does your child
dislike? _____

FOR INFANTS: Is your baby breast or bottle-fed? _____

What food is your baby eating right now?

Fruits _____ Juices _____ Veggies _____ Meats _____ Cereals _____ Milk/Formula _____

SLEEPING

Has your child had any sleeping problems? No _____ Yes _____

If "Yes", describe: _____

How long does your child usually sleep at night? _____

Does your child nap during the day? AM _____ PM _____

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

Does your child like a special object at naptime? _____

Does your child sleep in a crib or bed? _____

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HEALTH

Has your child ever had a serious illness? No _____ Yes _____

If "Yes", please describe: _____

Has your child ever had any operations? No _____ Yes _____

If "Yes", please describe: _____

Does your child take any medication daily? _____

If "Yes", what medication(s), and why? _____

Does your child have any special needs (feeding, learning, behavioral, etc)?

No _____ Yes _____

If "Yes", please describe: _____

Is your child now or did he/she ever receiving services from any organization or consultant?

If "Yes", when and who? _____

If "Yes" please share any test results that address your child's academic or psychological needs. _____

Has your child ever visited the dentist? No _____ Yes _____

Has your child had any of the following?

Whooping cough: No _____ Yes _____

Measles: No _____ Yes _____

Chicken pox: No _____ Yes _____

High Fever (over 103): No _____ Yes _____

Allergies: No _____ Yes _____

Serious Injuries: No _____ Yes _____

Mumps: No _____ Yes _____

Rubella: No _____ Yes _____

Pneumonia: No _____ Yes _____

Seizures: No _____ Yes _____

Eczema: No _____ Yes _____

Other: _____

Please elaborate on any conditions for which you checked "yes", or anything you feel should be brought to the attention of the CARE teachers or Nurse Consultant:
