RECTORY SCHOOL

Children At Rectory

INFANT • TODDLER • PRESCHOOL

CARe Parent and Child Information Sheet

Child's Name: _____Date of Birth: _____/_____/_____
Nickname? _____ 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: _____

Does your child have any pets? Please include names and type of animal: _____

_____

SOCIAL/EMOTIONAL DEVELOPMENT

Has your child been in child care before? _____

Is your child comfortable in group situations? _____

What kinds of activities does your child enjoy? _____

Are there activities that your child does not enjoy? _____

528 POMFRET STREET POMFRET, CT 06258 TEL. (860) 928-1808 FAX (860) 928-1591 EMAIL children@rectoryschool.org

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How would you describe your child's temperament and personality? _____

_____

Is there anything that frightens your child? _____

What soothes your child? _____

What are your hopes and or expectations for your child while he/she is at CARe? _____

_____

Is there anything regarding your family or your child that you would like to share with us that would help us know your child better? _____

_____

FEEDING

Does your child have any food allergies? _____If yes, please describe_____

Is your child on a special diet? ____Vegetarian ____Egg/Dairy/Nut free ____Vegan ____Other

What does your child use to drink? ____Bottle ____Sippy cup ____Open cup ____Nursing _____Other

Can your child eat with a spoon?_____ A fork? _____ Can you child feed himself/herself? _____

What are your child's favorite foods? _____

Are there foods that your child dislikes? _____

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

What food is your baby eating right now?

Fruits_____ Veggies _____Meats _____Cereals _____Milk/Formula _____Other _____

SLEEPING

Does your child nap? _____ How many times per day? _____ How long? _____

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

Does your child like a special object at naptime, a blanket, toy or pacifier? _____

Does your child sleep in a crib or bed? _____

How long does your child usually sleep at night? _____

TOILETING

Does your child use diapers? _____ Cloth_____ Disposable _____

If cloth, please remember that we are unable to launder diapers and they will be bagged and sent home unrinsed. Please provide a zippered or sealed bag for dirty diapers to be picked up at the end of the day.

Does your child use a potty or the toilet? _____

How does your child let you know they need to go to the bathroom? _____

Does your child need regular reminders to use the bathroom? _____

DEVELOPMENT

Do you have any concerns about your child's development? Yes_____ No_____

Please indicate any concerns you have in any of these areas (Hearing, Vision, Language, Gross Motor, Fine Motor, Social/Emotional, or Other)

_____

_____

_____

The following accommodation(s) may be required to effectively meet my child's needs while at CARe:

_____

_____

What is your child's primary spoken language? _____

Are other languages being spoken at home or used with your child? _____

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HEALTH

Has your child ever had a serious illness? _____ If yes, please describe: _____

Has your child ever had any operations? _____ If yes, please describe: _____

_____

Does your child take any medication daily? _____ If yes, what medication(s), and what is the medication taken for? _____
_____

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

When and by whom? _____
If services were provided to your child, please share any test results that address your child's academic or social/emotional needs.

Has your child ever visited the dentist? _____

Name of child's dentist _____ Phone # _____

Has your child had any of the following?

COVID-19	No_____Yes_____		
Whooping cough:	No_____Yes_____	Mumps:	No_____Yes_____
Measles:	No_____Yes_____	Rubella:	No_____Yes_____
Chicken pox:	No_____Yes_____	Pneumonia:	No_____Yes_____
High Fever (over 103):	No_____Yes_____	Seizures:	No_____Yes_____
Allergies:	No_____Yes_____	Eczema:	No_____Yes_____
Serious Injuries:	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:
_____
_____
_____
_____

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