**All about my child**

Thank you for helping us to understand this child’s care history, supporting a positive transition experience

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| Today’s Date: | Parent name(s): | |
| Child’s full name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Nickname(s): | | Child’s date of birth: |
| Family or friends that child might miss or talk about: | | |

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| **Caring for your child** | | | | | | | |
| Does your child have any known allergies? (if yes, please specify & describe reactions/treatment)  Medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Food: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | |
| Do you have a religious preference, affiliation, or cultural tradition(s)? (if yes, please explain) | | | | | | | |
| Does your child play well with other children? Do they have any preferred friends? | | | | | | | |
| Does your child have any specific fears or anxieties? (for example: animals, car rides, places, etc.) | | | | | | | |
| Does your child exhibit any behaviors that we should be aware of?  (unsafe play, toileting difficulties, tantrums, etc.) | | | | | | | |
| How do you prefer to comfort your child? | | | | | | | |
| Is there any other information you can share that might help make your child feel more comfortable with a new caregiver? | | | | | | | |
| **Daily Routines** | | | | | | | | |
| **Routine** | | **Time** | **Notes** | | | | | |
| **Sleep** | Wake up |  | How does your child wake up in the morning? What do they usually need or do 1st? | | | | | |
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| Nap? |  | Where & how long does your child typically nap?  How can you tell they are tired, & what do they need to fall asleep? | | | | | |
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| Nighttime |  | What is your child’s bedtime routine? (hygiene, stories/song/prayer, etc.)  Does your child usually sleep in a bed/room alone, or with others?  What does your child need to sleep? (night light/dark, quiet, comfort item, etc.)  Does your child wake during the night? How do you return them to sleep? | | | | | |
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| **Food & Meals** | Breakfast |  |  | | | | | |
| Lunch |  |  | | | | | |
| Dinner |  |  | | | | | |
| Snack(s) |  |  | | | | | |
| Does your child have any dietary restrictions? (if yes, please explain) | | | | | | | |
| What are your child’s favorite foods? | | | | What foods does your child dislike? | | | |
| Does your family usually eat meals together? If yes, what are your mealtime customs? | | | | | | | |
| **Activities** | Hygiene & personal care | | Is your child using the toilet independently, or do they need assistance?  How often & when does your child bathe/shower?  How do you care for your child’s hair? (products, styling, etc.)  Does your child prefer to dress themselves, or do they need assistance? | | | | | |
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| What does your child enjoy doing? What are their strengths & talents? | | | | | | | |
| Does your child participate in any activities outside of school/childcare?  (including clubs/groups, lessons, sports, etc.) | | | | | | | |
| Do you avoid any activities with your child because of their reaction or skillset?  (if yes, please explain) | | | | | | | |
| **School Information** | | | | | | | | |
| **Preferred location** | | | | **Teacher** | | **Start/drop off time:** | **End/pick up time:** | |
| School name: | | | | Name:  Phone number: | |  |  | |
| Childcare name &/or address: | | | | Name:  Phone number: | |  |  | |
| Does your child have or qualify for special services (IFSP or IEP), or receive accommodations in school?  (if yes, please explain) | | | | | | | | |
| Is there anything you want to share about your child’s school experience or situation? | | | | | | | | |

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| **Medical Information** | |
| **Preferred provider (name &/or clinic)** | **Phone number** |
| Pediatrician: |  |
| Dentist: |  |
| Medical specialist(s): |  |
| Does your child have any special medical conditions you would like us to know about? (if yes, please explain) | |
| Have there been any significant medical events in your child’s history? (if yes, please explain) | |
| Are there any mental health or emotional health concerns for your child? (if yes, please explain) | |
| How do you prefer your child is cared for when they are ill? (extra rest &/or cuddles, home remedies, etc.) | |

Please feel free to include additional pages as necessary.