## ALL ABOUT MY CHILD

Does your child have a history of the following? Check any that apply.   □Frequent colds □Stomachaches   □Headaches □Seizures   □Nosebleeds □Asthma   □Food Allergies □Seasonal Allergies   Note: If your child has a history of allergies and/or asthma, you will need to complete an additional Action Plan and Medication Authorization Form   Does your child have any eating problems?   Does your child have any eating problems?   Does your child have any dietary restrictions?   Anything else we should know about your child's current health or health history?   DevelopMENTAL HISTORY Has your child had group child care experiences before? □Yes □No If yes, please describe:	Child's name:			Date of Birth:		Class:
Dther members of the household (include ages for siblings) Please write Name—Relationship         Dther significant people in child's life (e.g grandparents who care for child):         Primary language spoken at home:	FAMILY BACKGRO	UND:				
Other significant people in child's life (e.g grandparents who care for child):         Primary language spoken at home:	Parents/Caregivers	s' names:				
Primary language spoken at home:	Other members of	the househ	old (inclue	de ages for siblings	) Please write N	lame—Relationship
Other languages spoken at home:	Other significant p	eople in chi	ld's life (e.	g grandparents wh	no care for child	):
List holidays celebrated at home:	Primary language s	spoken at ho	ome:			
HEALTH HISTORY         Does your child have a history of the following? Check any that apply.         Frequent colds       Stomachaches       Headaches       Seizures       Ear Infections         Nosebleeds       Asthma       Food Allergies       Seasonal Allergies         Note: If your child has a history of allergies and/or asthma, you will need to complete an additional Action Plan and Medication Authorization Form       Does your child have any eating problems?         Does your child have any dietary restrictions?	Other languages sp	ooken at ho	me:			
Does your child have a history of the following? Check any that apply.         □Frequent colds       □Stomachaches       □Headaches       □Seizures       □Ear Infections         □Nosebleeds       □Asthma       □Food Allergies       □Seasonal Allergies         Note: If your child has a history of allergies and/or asthma, you will need to complete an additional Action Plan and Medication Authorization Form       □Does your child have any eating problems?         Does your child have any dietary restrictions?	List holidays celeb	rated at hon	ne:			
Nosebleeds Asthma   Food Allergies Seasonal Allergies   Note: If your child has a history of allergies and/or asthma, you will need to complete an additional Action Plan and Medication Authorization Form   Does your child have any eating problems?   Does your child have any dietary restrictions?   Anything else we should know about your child's current health or health history?   DevelopMENTAL HISTORY   Has your child had group child care experiences before?   Yes   No   If yes, please describe:   Physical Development   Speech   Hearing	<b>HEALTH HISTORY</b> Does your child ha	ve a history	of the fol	lowing? Check any	that apply.	
Note: If your child has a history of allergies and/or asthma, you will need to complete an additional Action Plan and Medication Authorization Form   Does your child have any eating problems?   Does your child have any dietary restrictions?   Anything else we should know about your child's current health or health history?   DevelopMENTAL HISTORY   Has your child had group child care experiences before?   Yes   No   If yes, please describe:   Do you have any concerns about your child's:   Physical Development   Speech	□Frequent colds	□Stomach	naches	□Headaches	□Seizures	□Ear Infections
additional Action Plan and Medication Authorization Form   Does your child have any eating problems?   Does your child have any dietary restrictions?   Anything else we should know about your child's current health or health history?   DEVELOPMENTAL HISTORY Has your child had group child care experiences before? □Yes □No If yes, please describe:	□Nosebleeds	□Asthma		□Food Allergie	s 🗆 Seasonal	Allergies
Does your child have any dietary restrictions?   Anything else we should know about your child's current health or health history? DEVELOPMENTAL HISTORY Has your child had group child care experiences before? □Yes □No If yes, please describe:				-		l to complete an
Does your child have any dietary restrictions?   Anything else we should know about your child's current health or health history? DEVELOPMENTAL HISTORY Has your child had group child care experiences before? □Yes □No If yes, please describe:	Does your child ha	ve any eatin	ıg problen	ns?		
DEVELOPMENTAL HISTORY         Has your child had group child care experiences before?         If yes, please describe:						
Has your child had group child care experiences before? If yes, please describe: Do you have any concerns about your child's: Physical Development Social Development General Development Hearing	Anything else we s	hould know	about yo	ur child's current h	ealth or health	history?
If yes, please describe: Do you have any concerns about your child's: Physical Development Social Development General Development Speech Hearing	DEVELOPMENTAL	HISTORY				
□Physical Development □Social Development □General Development □Speech	-		-			
□Speech □Hearing	Do you have any co	oncerns abo	out your ch	nild's:		
	Physical Develop	oment	□Social I	Development	□General De	velopment
f yes, please explain:	□Speech		□Hearin	g		
	If yes, please expla	in:				

Child's strengths:
Child's likes and dislikes, special interest/activities:
My child has difficulty/may need help with these activities:
My child is afraid of:
My child gets frustrated when:
When my child gets upset, she/he:
Things I am working on with my child:
Rewards/consequences used at home for behavior:
What goals do you have for your child in school this year?
What expectations do you have for your child's teachers?
Anything else we should know about your child to help him/her have a successful year?

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_