

# Enrollment Questionnaire About Your Child

**Child's Name:** \_\_\_\_\_

**Nickname:** \_\_\_\_\_

1. What FOODS does your child especially like? \_\_\_\_\_
2. Especially Dislike? \_\_\_\_\_
3. Favorite toys, games, activities? \_\_\_\_\_
4. Is your child TOILET TRAINED? \_\_\_\_\_ What words does your child use for toilet? \_\_\_\_\_
5. How does your child express ANGER or frustration? \_\_\_\_\_
6. Does your child have any special FEARS? \_\_\_\_\_
7. When your child is upset, what helps to COMFORT him/her? \_\_\_\_\_
8. How do you DISCIPLINE your child? \_\_\_\_\_
9. Has your child been taking an afternoon NAP? \_\_\_\_\_ If so, how long? \_\_\_\_\_  
If not, why? \_\_\_\_\_
10. Special toy or blanket for NAP? \_\_\_\_\_
11. Special FAMILY situations? (*such as custody specifications, problems from situations, etc.*) \_\_\_\_\_  
\_\_\_\_\_
12. Anticipated ADJUSTMENT problems? \_\_\_\_\_
13. Any disorders/development (*slow/advanced*) diagnosis or suspected? \_\_\_\_\_  
\_\_\_\_\_
14. Previous childcare child has attended: \_\_\_\_\_
15. Any problems at previous daycare? \_\_\_\_\_
16. EXPECTATIONS of childcare: \_\_\_\_\_
17. Other COMMENTS: \_\_\_\_\_  
\_\_\_\_\_

## History

1. Last Physical Examination \_\_\_\_\_
2. Illnesses: (*please circle*) \_\_\_\_\_

***Does your child any problems with any of these?***

***Has your child had any of these diseases?***

Constipation

Asthma

Convulsions

Bronchitis

Diarrhea

Chicken Pox

Fainting Spells

Diabetes

Frequent Colds

Heart Disease

Frequent Ear Infections

Hepatitis

Frequent Sore Throat

Impetigo

Lice

Measles

Ringworm

Mumps

Skin Rash

German Measles

Soiling

Polio

Stomach Upset

Scarlet Fever

Urinary Problems

Tuberculosis

Worms

Whooping Cough

3. Other ILLNESSES? (*besides above*) \_\_\_\_\_
4. Has your child been HOSPITALIZED? (*explain*) \_\_\_\_\_
5. Has your child had INJURIES with fractures or loss of consciousness? (*explain*) \_\_\_\_\_  
\_\_\_\_\_
6. Last VISION test date \_\_\_\_\_ Last HEARING test date \_\_\_\_\_
7. Last DENTIST visit date \_\_\_\_\_
8. Any other members of your family with SERIOUS ILLNESS? \_\_\_\_\_ Explain: \_\_\_\_\_  
\_\_\_\_\_
9. Any other members of your family history of: ASTHMA \_\_\_\_\_ DIABETES \_\_\_\_\_ EPILEPSY \_\_\_\_\_