

**SLEEPING HABITS**

\*Does your child sleep in a crib? \_\_\_\_\_ Bed? \_\_\_\_\_  
Does your child become tired or nap during the day (include when and how long)? \_\_\_\_\_

*Please note: The American Academy of Pediatrics has determined that placing a baby on his/her back to sleep reduces the risk of Sudden Infant Death Syndrome (SIDS). SIDS is the sudden and unexplained death of a baby under one year of age. If your child does not usually sleep on his/her back, please contact your pediatrician immediately to discuss the best sleeping position for your baby. Please also take the time to discuss your child's sleeping position with your caregiver*

When does your child go to bed at night? \_\_\_\_\_ and get up in the morning? \_\_\_\_\_  
Describe any special characteristics or needs (stuffed animal, story, mood on walking etc) \_\_\_\_\_

**SOCIAL RELATIONSHIPS**

How would you describe your child: \_\_\_\_\_

Previous experience with other children/day care: \_\_\_\_\_

Reaction to strangers: \_\_\_\_\_ Able to play alone: \_\_\_\_\_

Favorite toys and activities: \_\_\_\_\_

Fears (the dark, animals, etc): \_\_\_\_\_

How do you comfort your child: \_\_\_\_\_

What is the method of behavior management/discipline at home: \_\_\_\_\_

What would you like your child to gain from this childcare experience? \_\_\_\_\_

**DAILY SCHEDULE:** Please describe your child's schedule on a typical day.  
\*For infants, please include awakening, eating, time out of crib/bed, napping, toilet habits, fussy time, night bedtime, etc.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is there anything else we should know about your child?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_