



Passion Care Academy

EARLY CHILDHOOD LEARNING CENTER
www.passioncareacademy.com

Getting to Know You Form

Child's legal name		Date of Birth		<input type="checkbox"/> Boy <input type="checkbox"/> Girl	
Does child respond to a nickname? <input type="checkbox"/> No <input type="checkbox"/> Yes <i>If yes, state nickname</i>					
Mother's name			Occupation		
Father's name			Occupation		
Parents are <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Live apart <input type="checkbox"/> Live together <input type="checkbox"/> Widowed <input type="checkbox"/> Never married					
Stepmother/Stepfather name(s)					
If child does not live with parents, who is primary caregiver?					
Primary caregiver relationship to child					
Mother's age at time of birth			Father's age at time of birth		
Length of pregnancy in weeks			Child's birth weight		
Child's health at birth <i>Describe any health problems or concerns</i>					
Was child hospitalized for any length of time after birth in the NICU? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If "Yes", please describe reasons and length of hospitalization:</i>					
List others living in child's household					
Name		Age	Relationship		
Name		Age	Relationship		
Name		Age	Relationship		
Name		Age	Relationship		
Name		Age	Relationship		
Check all conditions/illnesses the child has been treated for					
<input type="checkbox"/> Colic	<input type="checkbox"/> Flu	<input type="checkbox"/> Mumps	<input type="checkbox"/> Scarlet fever	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Rash
<input type="checkbox"/> Chicken pox	<input type="checkbox"/> Rubella	<input type="checkbox"/> Measles	<input type="checkbox"/> Stomach virus	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> TB
<input type="checkbox"/> RSV	<input type="checkbox"/> Strep	<input type="checkbox"/> Pertussis	<input type="checkbox"/> Impetigo	<input type="checkbox"/> Ear infection	<input type="checkbox"/> Headache
Has your child ever been hospitalized? (<i>Inpatient or outpatient</i>) <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If "Yes", describe the circumstances:</i>					
Has child ever had surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If "Yes", describe the circumstances:</i>					
Does your child have any chronic or debilitating illness? (<i>ex. Asthma, diabetes, etc.</i>) <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If "Yes", please explain:</i>					
Does your child take prescription medication(s) on a regular basis? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If "Yes", please explain:</i>					
Describe child's eating habits:					
Does your child have allergies? <i>Please include seasonal, environmental, and food allergies</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If "Yes", how are they treated/managed?</i>					
Describe child's personality: (<i>ex. Outgoing/shy/talkative/energetic/fearful/nervous/angry/quiet, etc.</i>)					

Child's favorite activities:			
Does your family use special words for bowel movements/urination/private parts?			
List former child care or home day care child attended <i>Please include length of time and age at attendance</i>			
Did your child like attending child care/home day care? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If "No", please explain</i>			
Reasons for leaving previous care			
Is there any information related to the child, family composition, previous experiences, etc. that might help us make the transition to our program easier for your child?			
With what adult does the child spend most of his/her time?			
Does child have opportunities to play with other children? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Are there any custody issues or visitation arrangements that we should be aware of? <i>A copy of a court order is necessary for us to prohibit a parent from picking up the child</i>			
Does child live in a smoke-free home? <input type="checkbox"/> Yes <input type="checkbox"/> No		Pets in the home? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Please list names and type of animal</i>	
Is there any particular aspect of our program especially important to your child/family? -			
Is there any information about your family's culture, ethnicity, language, or religion that you feel is important for us to know?			
Does your child have any imaginary friends?			
Are there any special fears or problems that we should know about?			
Does your child have any special needs? <i>Medical, developmental, social, mental health, etc.</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If "Yes", please explain:</i>			
Please indicate any family crises or problems that have occurred in the child's household:			
<input type="checkbox"/> Separation/divorce	<input type="checkbox"/> Parent's new job	<input type="checkbox"/> Death of family member	<input type="checkbox"/> Move to new home
<input type="checkbox"/> Death of pet	<input type="checkbox"/> Birth of sibling	<input type="checkbox"/> Family member illness	<input type="checkbox"/> Custody issues
<input type="checkbox"/> History of abuse	<input type="checkbox"/> Incarceration of family member		
<input type="checkbox"/> Other <i>Please describe</i>			

Infant/Toddler Students: Give child's age in months for first experiences with the following: <i>Write N/A if not yet accomplished</i>			
Solid Food	Pulling up	Sleep through night	Crawling
Walking	Drink from cup	First words	Use Spoon
Roll over	Stand alone	Climb stairs	Toilet trained

Infant/Toddler/Preschool Students		
Child's bedtime:	Problems with nightmares? <input type="checkbox"/> Yes	Bedwetting? <input type="checkbox"/> Yes <input type="checkbox"/> No

Usual waking time: Normal Naptime:	<input type="checkbox"/> No Sleep through the night? <input type="checkbox"/> Yes <input type="checkbox"/> No	Pacifier use? <input type="checkbox"/> Yes <input type="checkbox"/> No
Does child have comfort toy at bedtime? <i>(ex. Special blanket or stuffed toy)</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If "Yes", please describe:</i>		

What are you most hoping that your child takes from the childcare experience?

Do you have any questions or concerns about our childcare program?

Does your child have an IEP? Yes No *If "Yes", please provide us with a copy so that we can provide the best possible learning environment for your child*

How can we address Inclusion Needs for your child