

**1200 Clifton Avenue**

**Collingdale, PA 19023**

**Phone: 610-522-2101 – Fax: 610-522-9103**

**Getting To Know You**

**Child’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_**

Parent(s)/Family Section:

* Does your child have any parents that do not live in the home?

If yes, does your child visit this parent?

* Are there any custody issues that we should discuss?
* Does your child have any siblings (names and ages)?
* Does your child have any nicknames for family members?
* Is there any other information about your family’s composition that you would like to share?
* Is there any information about your child’s family culture, ethnicity, language, or religion that is important for us to know?
* What are your expectations of our program?
* Is there any particular aspect of an education program that is especially important to your child/ family?
* Do you have any questions about the Family Handbook?
* Do you have any questions about the program, curriculum, or facility?

Child Info Section :

* Has your child been in an early learning program or child care before?

If yes, would you share some information with us (Where? When? etc.)

Is there a reason for leaving that care that you would like to share with us?

* How does your child react to other children and adults?
* What do you anticipate will happen the first day that you leave your child with us?
* Are there any special problems or fears that we should know about?
* Is there any information that will help us make the first few days at CLLC easier for your child?
* Does your child have special needs (medical, developmental, social, mental health)?

If yes, do any of these special needs require special care from our teachers?

* Does your child have an IEP (Individualized Education Plan) or ISFP (Individualized Family Service Plan)?

If yes, what program/ individuals work with your child in regards to these special needs?

* Does your child have any allergies?

Food Allergies?

Environmental Allergies?

Medicine Allergies?

If yes, how are your child’s allergies treated?

* Do you have any special medical or dietary information for management in an emergency situation (medicine to keep on hand, people to call, etc.)?
* Any other medical or special needs?
* Describe your child’s schedule:

Normal waking time/ bedtime:

Nap time/s and duration of naps:

Meal times:

* Does your child do any of the following:

Nail biting?

Thumb sucking?

Stuttering?

* Regarding toileting habits:

Is your child toilet trained?

Does your child need to be reminded to go to the toilet during waking hours?

What words does your family use for bowel movements and urination?

* Tell us about your child’s

Favorite toys:

Favorite Games:

Food Likes and Dislikes:

* Does your child respond to any nicknames?
* Is there any other information you would like to share with us about your child?

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