Academy for Kids – Child's Profile

Child's Name _______________________________ Birthdate _____________

Nickname _____________ I have ____ brothers ____ sisters - ages: _________

How would you describe your child's personality? _______________________

Please list your child's favorite activities: _________________________________

Please list your child's favorite toys: _____________________________________

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Has your child been in day care before? ( ) yes ( ) no
If yes, please give child's last Daycare Provider information:

Name _______________________________________ Phone (_____)_____________

Dates attended: from ____________ to _____________

Why was care terminated? ____

May I contact them for a reference? ( ) yes ( )no

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Does your child have a regular bedtime schedule ( )yes ( )no

What time does your child usually go to bed at night? ________________

What time does your child usually wake up in the morning? __________

Does your child have trouble sleeping? ______ Night Terrors? Walk in sleep? _____ Trouble going to sleep? _____ Other _______________________

What time does your child usually take an afternoon nap? ______________

Are there any special dolls, blankets, etc. that your child needs to go to sleep? ( ) yes ( ) no Please list. ________________________________

What is their disposition when waking up? (happy, grouchy, clingy, slow)

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Is your child potty trained? ( ) yes ( )no Do you wish me to help you with potty training while here? ( ) yes ( ) no What words are used at home for: urinating ________, bowel movements ______, Any other information that I should know about potty training practices at home: ____
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Has or does your child have any known health problems? (   )yes (   )no
If yes, describe: ____

Does your child need regular medication for the health problem? (   ) yes (   )no If yes, what and when is it given? ______________________________

Does your child have any known allergies (   ) yes   (   ) no

If yes, please list allergens: ____

Special instructions in the event of an allergic reaction: ________________

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Has your child had any of the following communicable diseases (circle all

that apply Chicken Pox, Measles, Mumps, Other _______________________

Is your child, prone to: (circle all that apply) upset stomach, colds,

Seasonal allergies, ear aches, headaches, sore throats, nose bleeds, other

____

Are there any indications of vision or hearing problems (   ) yes   (   ) no

Has your child had any recent serious illnesses (   )yes   (   )no   If yes,

describe: ____

Does your child have any physical or mental disabilities (   ) yes (   ) no

If yes, explain: ____

Do you have a back-up plan if your child is ill and cannot attend or

becomes ill and must be picked up (   ) yes   (   )no

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What are your child's eating habits (times child usually eats, mind trying

new things, etc.) ____

If your child is drinking formula, do they prefer it warm or cool? ________

Child's usual dining habits: (circle all that apply) High Chair, Booster Seat

Feeds Self, Uses Utensils, Bottle, Sipper Cup, Regular Cup, ______________

Favorite Foods: ____

Strong Dislikes: ____

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Special instructions concerning care, medications or diet not mentioned above:
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