TODDLER FACT SHEET

Child's Name _____ Birthdate_____

Primary Contact's Name _____

HEALTH

Does your child seem well most of the time? Yes___ No(explain)_____
Does your child take any regular medications, vitamins, or laxatives? Yes _____ No ___
Are you concerned about your child's hearing? Yes _____ No _____
Are you concerned about your child's vision? Yes _____ No _____
Does your child have any disabilities? Yes _____ No ____
Has your child been hospitalized? Yes _____ No ____
Has your child had any of the following:
premature birth Yes _____ No ____
birth injury Yes _____ No ____
birth defects Yes _____ No ____
convulsions Yes _____ No ____
seizures Yes _____ No ____
asthma Yes _____ No ____
head injury Yes _____ No ____
Is your child's skin highly sensitive to anything? _____

Are there any other significant illnesses that we need to know about? _____
_____

What arrangements have you made for the care of your child should he become ill at the center?
_____

DEVELOPMENTAL HISTORY

How do you comfort your child? _____
What are your child's favorite toys? _____
What are your child's favorite activities? _____
Does your child have a "fussy" time? Yes _____ No _____ When?_____
How do you handle such time(s)? _____
Does your child use a pacifier? Yes _____ No _____
Does your child suck his thumb? Yes _____ No _____
How has your child been affected by teething? _____

SLEEPING

Do you have any special ways of helping your child get to sleep? _____
_____
What is your child's present sleeping schedule?
Morning Nap from_____to_____
Afternoon Nap from_____to_____
Night Time from_____to_____

Learning Connections of Galesburg

FEEDING

Breakfast_____

Lunch_____

Snacks_____

Dinner_____

Does your child handle a cup or spoon? _____

Does your child eat in a high chair? Yes _____ No _____

Does your child eat at a table? Yes _____ No _____

Are there any other significant feeding issues that we need to know about? _____

_____

TOILETING

Has toilet training been attempted? Yes _____ No _____

If yes, what is used at home? potty chair _____ special toilet seat _____ regular toilet seat _____

"pull-ups" _____ training pants _____

How frequently does your child have a bowel movement? _____

What time of the day? _____

Is diarrhea _____or constipation _____a problem?

If so how do you treat it? _____

Is diaper rash a problem? Yes _____ No _____

If so how do you treat it? _____

OTHER INFORMATION

Does your child have any specific comfort items? _____

_____

What are your child's favorite toys and/or activities? _____

_____

Does your child have special words/names for objects and/or people? _____

_____

_____

Are there any other facts that we should know about your child?_____

_____

_____

Thank you for taking time to complete this form. It will be used in planning to meet your child's needs.