



GETTING TO KNOW YOU INFORMATION FORM

To be completed by parent/guardian prior to child's first day of attendance

Child's Legal Name	Birthdate	<input type="checkbox"/> Boy	<input type="checkbox"/> Girl
Does Child Respond to A Nickname? <input type="checkbox"/> No <input type="checkbox"/> Yes <i>Please State Nickname</i>			
Parent/Guardian Name		Occupation	
Parent/Guardian 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			

Length Of Pregnancy	Child's Birth Weight	
Child's Health At Birth <i>Please describe any health problems or concerns</i>		
Was Child Hospitalized For Any Length Of Time After Birth In Neonatal Intensive Care? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If "YES," please describe reasons and length of hospitalization:		
List Others Living in Child's Household		
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"/> Chicken Pox	<input type="checkbox"/> Rubella	<input type="checkbox"/> Measles
<input type="checkbox"/> RSV	<input type="checkbox"/> Strep	<input type="checkbox"/> Pertusis
<input type="checkbox"/> Scarlet Fever	<input type="checkbox"/> Ear Infection	<input type="checkbox"/> Diarrhea
<input type="checkbox"/> Stomach Virus	<input type="checkbox"/> Cold	<input type="checkbox"/> Headache
<input type="checkbox"/> Impetigo	<input type="checkbox"/> TB	<input type="checkbox"/> Rash
Has child Ever Been Hospitalized? (<i>Inpatient or Outpatient</i>) <input type="checkbox"/> Yes <input type="checkbox"/> No If "YES," describe the circumstances:		
Has Child Ever Had Surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No If "YES," describe the circumstances:		
Does Child Have Any Chronic Or Debilitating Illness? (Example: asthma, diabetes, etc.) <input type="checkbox"/> Yes <input type="checkbox"/> No (If "YES," please explain:		
Does Child Take Prescription Medications? <input type="checkbox"/> Yes <input type="checkbox"/> No If "YES," please list:		

Does Family Have Any Concerns About Child's General Health or Development? Yes No If "YES," please describe:

Describe Child's Eating Habits:

Describe Child's Personality (Example: outgoing/shy/talkative/fearful/angry/quiet, etc.)

Child's Favorite Activities:

List Former Child Care or Home Day Care Child Attended *Please include length of time and age at attendance*

Did Your Child Like Attending Child Care/Home Day Care? Yes No If "NO," please explain:

Reason For Leaving Previous Care

Are Records Available From Previous Child Care Arrangement?

Is There Any Information Or Circumstances Related To The Child, Family Composition, Previous experiences, etc., That Might Help Us Make The Transition To Or First Few Days Of Participation In Our Program Easier For Your Child?

With What Adult Does Child Spend The Most time?

Does Child Have Opportunities To Play With Other Children? Yes No If "YES," please explain:

Are There Any Custody Issues or Visitation Arrangements That We Should Be Aware Of? *For instance, does your child have a parent that does not live in the home; does your child visit this parent, etc.?*

Does Child Live In A Smoke Free Home? Yes No Pets In The Home? No Yes Describe

Is There Any Particular Aspect Of Our Program Especially Important To Your Child/Family?

Is There Any Information About Your Family's Culture, Ethnicity, and Language Or Religion That Is Important For Us To Know?

Would You Or Your Family Like To Be A Resource For Any Cultural, Awareness Activities?

Are You Interested In Volunteering For Classroom Activities or Special Events?

Are There Any Other Ways You Would Like To Be Involved?

Are There Any Talents Or Interests You Would Like To Share With Us?

Does Your Child Have Any Imaginary Friends?

Are There Any Special Problems Or Fears That We Should Know About?

Does Child Have Any Special Needs? Medical, developmental, social, mental health, etc. Yes No If "YES," please explain.

Do Any Of These Special Needs Require Special Attention By Our Teachers?

Does Your Child Have An IEP (*Individualized Education Plan*) Or IFSP (*Individualized Family Service Plan*)?

No Yes-Note: if "YES," please provide a copy of the plan so we can provide the best possible experience for your child.

What Program Or Individuals Work With Your Child/Family In Regards To Any Special Needs:

Would You Sign A Release Of Information With Them So They Can Speak With Us About How To Provide Support To Your Child?

Yes No, not at this time

Do You Have Any Special Medical or Dietary Information We would Need To Be Aware Of For Management In An Emergency Situation?
(Ex: medicine to keep on hand)

Please Indicate Any Family Crises Or Problems That Have Occurred In Child's Household

Separation/Divorce Parent's New Job Death of Family Member Move To New Home

Death of Pet Birth of Sibling Family Member Illness Custody Issues

Other (*describe*):

Infant/Toddler Students: Give Child's Age In Months For First Experiences With The Following:

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 <input type="checkbox"/> No	Problems With Bedwetting? <input type="checkbox"/> Yes <input type="checkbox"/> No
Usual Waking Time	Sleep Through The Night? <input type="checkbox"/> Yes <input type="checkbox"/> No	Does Child Use A Pacifier? <input type="checkbox"/> Yes <input type="checkbox"/> No
Does Child Use A Comfort Buddy At Bedtime? Example: special blanket or stuffed toy <input type="checkbox"/> Yes <input type="checkbox"/> No If "YES," please describe:		

FCCC is required to maintain Civil Rights Compliance standards. For this purpose, we ask that you provide the following information.

Is your child: Black Hispanic White Native American Asian/Pacific Islander Other

Language used in home:

English Spanish Chinese (specify dialect) Russian Cambodian Vietnamese Other (specify language)

Is There Any Other Information You Would Like To Share With The Program That Would Be Helpful For The Teachers Or Which Would Be Useful In Ensuring A Smooth Transition to Care At FCCC?



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