INTAKE FORM
FAITH CHILD CARE
CHILDREN OVER 2

Name of child _____ Birth Date _____
Address _____ Home Phone _____

Mother's name _____ Father's name _____
Marital Status: Single _____ Married _____ Separated _____ Divorced _____
Length of status _____
If applicable, Stepfather's name _____ Stepmother's name _____

Custody/visiting arrangements if applicable (for pick-up reasons)
_____
_____

Siblings: Name/nickname _____ Age _____
Name/nickname _____ Age _____
Name/nickname _____ Age _____

PERSONAL INFORMATION

Does your child have his/ her own room?_____ If not with whom?_____
Has your child had group play experience? Yes No
Does your child have neighborhood playmates? Yes No
Names of playmates:_____
When and with whom does your child watch TV? _____
What is your child's favorite type of TV show? _____
Does your child have any speech problems?_____
Does your child have any other problems of concern? _____
_____

What method of behavior management is used at home?
_____
_____

What is your child's reaction to this method of discipline?
_____
_____

How would you describe your child's personality?
_____
_____

Does your child have any fears? _____
What is your child's reaction?_____

What is the best way to comfort?_____

Is your child right or left handed? _____

Are there any ethnic practices or holidays we should be aware of?
_____

What is your child's usual meal time?
Breakfast _____ Lunch _____ Dinner _____
Any known eating problems?_____
Is your family vegetarian? Yes No
What is your child's favorite food _____ Most disliked food_____
Any known dietary restrictions?_____

What is your child's usual bedtime?_____ Wake-up time? _____

What are your child's favorite indoor activities? _____
outdoor activities? _____
Does your child enjoy swimming? Yes No

HEALTH

Does your child run high fevers easily? Yes No
Does your child have frequent colds? Yes No Frequent ear infections? Yes No
Has your child ever had a serious injury?_____
Is your child allergic to anything? _____
Has your child ever had the following?
Vision Test Yes No
Hearing Test Yes No
Dental check-up Yes No
Does your child have speech problems? Yes No Explain _____
Does your child wear corrective shoes? Yes No
Does your child have any other corrective needs? Yes No
If yes, please explain _____

If you have any other information about your child that you feel would be beneficial for us to know, please use the space below.

Thank you for taking the time to answer these questions. We look forward to working with you and your child.