Toddler All About Me

Child Name (last, first, middle): _____DOB_____

Does your child have any allergies? ☐ Yes ☐No If so, what allergies does your child have? _____

How should we respond if he/she has an allergic reaction? _____

Has your child had a previous serious illness or injury, or hospitalization during the past 12 months?

☐ Yes ☐ No If yes, please Explain: _____

Special Instructions:

Type of milk _____

Juice Yes or No

Table Food or Baby Food

Pacifier Yes or No

Diaper Cream _____

Any medications: _____

Current on immunizations? _____

Special Instructions _____

When your child gets upset, what helps him/her calm down? _____

Are there any particular routines that are particularly helpful at naptime? _____

_____

What activities do you like to do with your child? _____

What activities does your child like to do when playing with other children? _____

_____

What does your child like to do when he/she is playing alone? _____

Tell me about your family (i.e. child's parents, siblings, grandparents, and other extended family) _____

_____

Who lives in your household? _____

I verify that the above assessment was discussed with the family.

Signature of Director _____ Date: _____

I verify that the director appropriately relayed the information concerning my child's assessment.

Signature of Parent or Legal Guardian _____ Date: _____

Updated (signature) _____Date: _____

Updated (signature) _____Date: _____