Passion Care Academy 1

EARLY CHILDHOOD LEARNING CENTER
3727 Wrangle Hill Road,
Bear, Delaware 19701
Phone: (302) 832-2622 Fax: (302) 832-2679

Getting to Know You Form

Child's legal name	Date of Birth	□Boy □ Girl
Does child respond to a nickname? □No □Yes *If yes, state nickname*		
Mother's name	Occupation	
Father's name	Occupation	
Parents are □Married □Single □Divorced □Live apart □Live together □Widowed □Never married		
Stepmother/Stepfather name(s)		
If child does not live with parents, who is primary caregiver?		
Primary caregiver relationship to child		
Mother's age at time of birth	Father's age at time of birth	
Length of pregnancy in weeks	Child's birth weight	
Child's health at birth *Describe any health problems or concerns*		
Was child hospitalized for any length of time after birth in the NICU? □Yes □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
Name	Age	Relationship

Check all conditions/illnesses the child has been treated for

□Colic □Chicken pox □RSV	□Flu □Rubella □Strep	□Mumps □Measles □Pertussis	□Scarlet fever □Stomach virus □Impetigo	□Diarrhea □Pneumonia □Ear infection	□Rash □TB □Headache

Has your child ever been hospitalized? *(Inpatient or outpatient)* □Yes □No *If "Yes", describe the circumstances:*

Has child ever had surgery? □Yes □No *If "Yes", describe the circumstances:*

Does your child have any chronic or debilitating illness? *(ex. Asthma, diabetes, etc.)* □Yes □No *If "Yes", please explain:*

Does your child take prescription medication(s) on a regular basis? □**Yes** □**No** ***If "Yes", please explain:***
Describe child's eating habits:
Does your child have allergies? ***Please include seasonal, environmental, and food allergies*** □**Yes** □**No** ***If "Yes", how are they treated/managed?***
Describe child's personality: ***(ex. Outgoing/shy/talkative/energetic/fearful/nervous/angry/quiet, etc.)***
Child's favorite activities:
Does your family use special words for bowel movements/urination/private parts?
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***
Reasons for leaving previous care
Is there any information related to the child, family composition, previous experiences, etc. that might help us make the transition to our program easier for your child?
With what adult does the child spend most of his/her time?
Does child have opportunities to play with other children? □**Yes** □**No**
Are there any custody issues or visitation arrangements that we should be aware of? ***A copy of a court order is necessary for us to prohibit a parent from picking up the child***

Does child live in a smoke-free home? □**Yes** □**No**	**Pets in the home?** □**Yes** □**No** ***Please list names and type of animal***

Is there any particular aspect of our program especially important to your child/family? **-**
Is there any information about your family's culture, ethnicity, language, or religion that you feel is important for us to know?

Does your child have any imaginary friends?
Are there any special fears or problems that we should know about?
Does your child have any special needs? ***Medical, developmental, social, mental health, etc.*** **□Yes □No** ***If "Yes", please explain:***

Please indicate any family crises or problems that have occurred in the child's household:			
□Separation/divorce **□Death of pet** **□History of abuse**	**□Parent's new job** **□Birth of sibling** **□Incarceration of family member**	**□Death of family member** **□Family member illness**	**□Move to new home** **□Custody issues**
□Other ***Please describe***			

Infant/Toddler Students: Give child's age in months for first experiences with the following: ***Write N/A if not yet accomplished***			
Solid Food **Walking** **Roll over**	**Pulling up** **Drink from cup** **Stand alone**	**Sleep through night** **First words** **Climb stairs**	**Crawling** **Use Spoon** **Toilet trained**

Infant/Toddler/Preschool Students		
Child's bedtime: **Usual waking time:** **Normal Naptime:**	**Problems with nightmares? □Yes □No** **Sleep through the night? □Yes □No**	**Bedwetting? □Yes □No** **Pacifier use? □Yes □No**
Does child have comfort toy at bedtime? ***(ex. Special blanket or stuffed toy)*** **□Yes □No** ***If "Yes", please describe:***		

What are you most hoping that your child takes from the childcare experience?
Do you have any questions or concerns about our childcare program?
Does your child have an IEP? □Yes □No ***If "Yes", please provide us with a copy so that we can provide the best possible learning environment for your child***
How can we address Inclusion Needs for your child