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www.bambinicdc.com

First Day of Attendance (mm/dd/yyyy)

PARENT / CHILD NAME AND ADDRESS

Name – Child (Last, First, MI)		Nickname (if any)	Birthdate (mm/dd/yyyy)
Name – Parent(s) (Last, First, MI)			Telephone Number – Home
Address – Parent(s) (Street, City, State, Zip Code)			

HEALTH Note: Health conditions that may affect the care of the child must be recorded on the department's form, Health History and Emergency Care Plan. The form should be shared with any person who provides care for the child.

Child has frequent colds, ear infections, colic, etc. – Describe.

UPDATES

MEALS

Current feeding schedule	Length of time on current schedule
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Food type

Formula Strained Junior Table Milk type – Specify:

New food timetable

When eating, child is –

Held in lap In highchair Other – Specify:

Feeds self

Yes No If "Yes", uses: Spoon Fork Hands

Special feeding problems

Yes No If "Yes" – Specify:

Food allergies

Yes No If "Yes" – Specify:

Favorite foods – Specify.

Refused foods – Specify.

UPDATES

SLEEP

Current sleep schedule

Length of time on current schedule

Falls asleep easily

 Yes No

Mood upon awakening – Describe.

Takes favorite toy(s) to bed – **child over age 1 year** Yes No If "Yes" – list toy(s):Sleep position – **child under age 1 year****Note:** Children under age 1 year must be placed to sleep on their back unless a written statement from the child's physician is attached. Back for children under age 1 year Side or stomach (physician statement attached)Sleep position – **child over age 1 year** Back Side or stomach

UPDATES

DIAPERING / TOILETING

Diaper – type

 Cloth Disposable

Diapers provided by parent

 Yes No

Plastic pants used

 Always Never Sometimes If "Sometimes" – Specify:

Highly sensitive skin

 Yes No

Frequent diaper rash

 Yes No

Lotions, powders or salves used

 Yes No If "Yes", product name(s) – Specify:

Toilet training attempted

 Yes No If "Yes", describe routine.

Type of toilet seat used at home

 Potty chair Special toilet seat Regular toilet seat

Regular bowel movements

 Yes No How often.

Time(s) of day:

Toileting problems

 Yes No If "Yes" – Describe.

UPDATES

VERBAL COMMUNICATION

Family speaks what language – Specify.

 English Other If "Other" – Specify:

Age child began talking

Child speaks in

 Words Sentences

Words used to describe special needs – Specify.

UPDATES

COMFORTING

Does child have a fussy time?

Yes No If "Yes" – Specify time.

How is fussy time handled?

Child likes to be:

Held Sung to Rocked Read to Other – Specify:

Special things you say or do to comfort child.

UPDATES

SELF-EXPRESSION

What causes your child to feel angry or frustrated?

What frightens your child and how is it shown?

How does your child express feelings of happiness, enjoyment, etc.?

Additional comments

UPDATES

PHYSICAL AND SOCIAL DEVELOPMENT

Is your child able to – (Check all that apply)

Sit up alone Pull up Crawl Walk holding on Walk without support

Yes No Is your child used to playmates?

Comments

UPDATES

MISCELLANEOUS

Child's **indoor** favorite toys and activities – Specify.

Child's **outdoor** favorite toys and activities – Specify.

By providing complete information about your child, you will be assisting staff in creating a positive experience for him / her while in care. List any information about your child's habits, abilities or personality that you feel will be helpful to the staff while caring for your child.

UPDATES

SIGNATURE – Parent or Guardian

Date Signed