



CAHABA VALLEY LEARNING CENTER  
151 Narrows Parkway, Suite E, Birmingham, Alabama 35242

**About Your Child (age 6 wks – 23 months)**

**Please answer only the questions that apply to your child. If the answer is n/a or if you feel uncomfortable answering any item, then the line can be left blank.**

1. What FOODS does your child especially like? \_\_\_\_\_

2. Especially DISLIKE? \_\_\_\_\_

3. Favorite toys, games, activities? \_\_\_\_\_

4. Is your child on formula or breast milk? \_\_\_\_\_ If Formula, what brand? \_\_\_\_\_

5. How frequently (approx.) is your child fed? \_\_\_\_\_

6. Does your child have any special FEARS? \_\_\_\_\_

Explain \_\_\_\_\_

7. When your child is upset, what helps to COMFORT him/her? \_\_\_\_\_

8. How does your child express ANGER or frustration? \_\_\_\_\_

9. How frequently (approx.) does your child NAP? \_\_\_\_\_ Approx. how long? \_\_\_\_\_

10. Is your child accustomed to having a toy or blanket for NAP? \_\_\_\_\_

11. What is your child's disposition upon waking up? happy, grouchy, clingy, slow, \_\_\_\_\_

12. Special FAMILY situations? (such as *custody specifications, problems arising from situations, etc.*) \_\_\_\_\_

\_\_\_\_\_

13. Anticipated ADJUSTMENT problems? \_\_\_\_\_

14. Any disorders/developmental (slow, advanced) diagnosed or suspected? \_\_\_\_\_

\_\_\_\_\_

15. Previous childcare child has attended: \_\_\_\_\_

16. Any problems at previous daycares? \_\_\_\_\_

17. What different would you like to see take place at our center \_\_\_\_\_

18. Any brothers or sisters at home? (Please list age) \_\_\_\_\_

Other COMMENTS? \_\_\_\_\_



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Health History

1. Child's name \_\_\_\_\_ Birth Date \_\_\_\_\_
2. Last Physical Examination \_\_\_\_\_
3. Has or does your child have any known health problems? ( ) yes ( ) no If yes, describe:  
\_\_\_\_\_
4. Does your child need regular medication? ( ) yes ( ) no If yes, what and when is it given?  
\_\_\_\_\_
5. Does your child have any known allergies? ( ) yes ( ) no If yes, please list allergens:  
\_\_\_\_\_
6. Special instructions in case of an allergic reaction:  
\_\_\_\_\_

7. Illnesses: (if yes, please circle and list approximate date)

Does your child have any problems with any of these?

Has your child had any of these diseases?

Constipation

Asthma

Convulsions

Bronchitis

Diarrhea

Chicken Pox

Fainting Spells

Diabetes

Frequent Colds

Heart Disease

Frequent Ear Infections

Hepatitis

Frequent Sore Throats

Impetigo

Lice

Measles

Ringworm

Mumps

Skin Rash

German Measles

Soiling

Polio

Stomach Upsets

Scarlet Fever

Urinary Problem

Tuberculosis

Worms

Whooping Cough

8. Other ILLNESSES? (besides above) \_\_\_\_\_
9. Has your child been HOSPITALIZED? (explain) \_\_\_\_\_
10. Has your child had INJURIES with fractures or loss of consciousness? (explain)  
\_\_\_\_\_  
\_\_\_\_\_
11. Last VISION Test Date \_\_\_\_\_ Last HEARING Test Date \_\_\_\_\_
12. Last DENTIST Visit Date \_\_\_\_\_
13. Any other members of your family with SERIOUS ILLNESS recently? (explain)  
\_\_\_\_\_  
\_\_\_\_\_
14. Any other members of your family history of: ASTHMA \_\_\_ DIABETES \_\_\_ EPILEPSY \_\_\_



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Please provide an example of a typical day in your child's life: (be sure to include eating, napping, playtime, etc.)