SCOPE EDUCATION SERVICES
EMPLOYEE DAY CARE PROGRAM

INTAKE FORM

CHILD'S NAME_____ **BIRTHDATE:**_____
Name your child prefers to be called: _____
Describe your child briefly (physical appearance, personality, abilities) _____
_____
List brothers and/or sisters: _____Age:_____
_____Age: _____
_____ Age: _____
_____Age: _____

MEDICAL HISTORY
Was there anything unusual about birth (premature, birth trauma)? _____
_____
Any history of colic?:_____
Allergies (asthma, medications, food, insect bites, other) _____
_____
List medication(s) given regularly (if applicable):_____
If applicable, please provide the name of the medication to be administered to your child:

Note: If the administration of medication is required, please attach doctor's specific direction on how and when to administer this medication.
Is your child's overall functioning age-appropriate?_____
Any identified concerns with hearing or vision? _____
Physical disabilities _____
Major illness/surgery _____ Date(s): _____
Has child ever been hospitalized? _____ Explain: _____
Coordination problems _____
Frequent physical complaints (headaches, stomach aches, etc.) _____
What communicable diseases has child had? _____
Upper respiratory problems _____
Diseases which run in the family _____
Does child have a "fussy" time? _____ When? _____
How handled? _____
Is child's skin highly sensitive? _____ Do you use:__ Oil __Powder __Lotion__ Other
Has toilet training been attempted? _____
If "YES" have you used: Potty chair? ____ Toilet seat insert? ____ Toilet seat? _____
Are bowel movements regular? _____How many per day?_____What time? _____
How frequently do accidents occur? _____
Is diarrhea or constipation a problem? _____

SLEEPING HABITS

What time does child go to bed? _____ Awaken? _____
When is he/she ready for sleep? _____ Does he/she have own room?_____
Does he/she have own bed?_____ Does he/she walk/talk/cry at night? _____
What does he/she take to bed with him/her? _____
What is his/her mood on awakening? _____
Does he/she take naps? _____ From when? _____ To when? _____

SOCIAL RELATIONSHIPS

Has he/she had any experience playing with other children? _____
By nature is he/she friendly? _____Aggressive? _____ Shy? _____ Withdrawn?____
Please describe relationship/interactions with brothers and sisters:

_____
Is he/she known by any children in the Center? _____
What makes him/her upset? _____
How does he/she show feelings? _____
What methods do you use when he/she behaves in a way that you do not approve of? ___
_____
Who does most of the disciplining? _____
What frightens your child? _____
Favorite toys and activities at home: _____
Does he/she like to be read to? _____ Listen to music? _____
Does he/she prefer to play outdoors? _____
List child's favorite activities: _____
_____
Describe child's typical daily schedule _____
_____
_____
_____
_____
Length of time this schedule in use _____
Have records of feeding been kept? _____
Any special feeding problems? _____
Any dietary restrictions? _____
Does he/she enjoy eating? _____
How has child been fed? Held in lap _____ High chair _____ Other_____
Does child use pacifier? ____ Suck his/her thumb? ____
Does your child crawl? ____ Walk with support? ____
In what particular ways can we help your child this year? _____
_____
_____
_____
Additional comments:_____
_____

Completed by _____ on _____ 20_____