

Student Fact Sheet Ages 2.5-4

Please fill out this form for your child. It will help our teachers get to know your child better.

Child's Name: _____ Date of Birth: _____

Dressing/Toileting

Can your child dress him/herself? Yes ___ No ___

Manage button? Yes ___ No ___ Zippers? Yes ___ No ___

Need help in the bathroom? Yes ___ No ___

Play and interactions with others

Has your child attended daycare/preschool prior? Yes ___ No ___

Play interests? _____

Favorite Activity? _____

Is your child outgoing or shy? _____

Is your child fearful of new situations and strangers? Yes ___ No ___

If yes explain their reaction. _____

Is your child afraid of anything else (sirens, clowns)? Yes ___ No ___

Does your child become upset if left by you? Yes ___ No ___

Sleeping/Nap Time

Does your child take a nap? Yes ___ No ___

Does your child have a special sleeping companion? Yes ___ No ___

Eating Habits

What are your child's favorite foods? _____

Does your child have a habit of putting too much food in their mouth during meals? Yes ___ No ___?
(possible choking hazard we need to watch out for)

Can your child feed themselves? Yes ___ No ___

Is your child a picky eater? Yes ___ No ___

Does your child have any food allergies? Yes ___ No ___

If yes, what are they? _____

Please list any other important information or special instructions on the care of your child below:

Signature _____

Date _____