Infant Questionnaire

Student Name: _____

Birth Date: _____ Today's Date: _____

In order to get to know your child better we ask that you please fill out this form and return it with your application**.**

General Information

Primary Language spoken at home: _____

Mother's occupation: _____

Mother's place of business: _____

How many hours per day does mom work? _____How often is mom out of town? _____

Father's occupation: _____

Father's place of business: _____

How many hours per day does dad work? _____How often is dad out of town? _____

Health Information

Was your child adopted? Yes No Did your pregnancy go to full term? Yes No

Were there any complications with your pregnancy? Yes No If so, what kind? _____

_____

What illnesses has your child had? _____

High Fever: _____When did this fever occur? _____How long did it last? _____

Does your child have any allergies? ***** Yes No If yes, what kind? _____

_____

Does the allergy require maintaining an EPI Pen or other medication at school? ***** Yes No

Does your child have any medical condition that requires immediate access to medication or a specific response from staff? ***** Yes No

Is your child sun sensitive? Yes No Is your baby prone to diaper rash? Yes No

Is your child prone to constipation? Yes No Is your child prone to ear infections? Yes No

Does your child have eczema or skin dryness? Yes No

Is your child taking any daily medication? Yes No If so, what kind? _____

_____

Does your child have any special needs that we should be aware of? Yes No

If yes, please explain:

_____

Does your child have any vision or hearing problems? Yes No If so, explain: _____

_____

Does our child have any vision or hearing problems? Yes No If so, explain: _____

_____

*** Upon acceptance you will be provided with a form to share more detailed information**

Family and Childcare Information

Does your child have any siblings? Yes No

Name	Age	Describe Relationship

Parents' marital status: _____

With whom does your child live? _____

Likes and Dislikes

What activities does your family enjoy doing together? _____

_____

Is your infant exposed to T.V. or videos? Yes No How long? _____

Is your infant exposed to floor time? Yes No

Does your infant sleep in his or her own room? Yes No

How often is our infant in a playpen, swing or walker? Not often Often

Does your baby spend uninterrupted time outside each day? Yes No

How would your describe your baby's temperament? Easy Difficult Slow to warm up

Routines

Are meals at a set time? Yes No Where are meals eaten?_____

Are meals eaten with adults? Yes No Is your child on solids? Yes No

How often?_____ What kinds?_____

_____

Was/is your child breastfed? Yes No

What time does your child go to bed?_____ What time does your child wake up?_____

Does your child sleep through the night? Yes No If not, how often does he/she awake?_____

What do you do to get him/her back to sleep?_____

Is your child prone to nightmares? Yes No Does your baby sleep with you? Yes No

Describe your morning routine: _____

_____

Describe your evening routine: _____

_____

Do you read to your infant? Yes No Do you talk to your infant? Yes No

Describe your actions? _____

_____

Is your infant surrounded by many other people usually or just his/her immediate family?

_____

How long will your child be in our care each day? (Program hours are from 7:30-4:30)

_____

Miscellaneous

Are you aware that Villa Montessori School requests each family to volunteer ten hours of time, per year? Yes No

Do you know that our program ends at 12 months and walking steadily for your infant and at that time he/she will start a phase-in process in the Villa Toddler program? Yes No

Are you committed to putting necessary time into Villa's phase-in process? Yes No

Are you aware of the differences between a Montessori infant program and traditional infant care settings? Yes No

Are you willing to follow our program's guidelines with your infant at home? Yes No

Do you have any special talents that you would like to share with Villa? Yes No If yes, what?

_____

What are your goals for your child this year? _____

_____

_____

Are there any other comments that your feel would be helpful? _____

_____

_____