



Toddler I Questionnaire

Student Name: _____

Birth Date: _____ Today's Date: _____

In order to get to know your child better we ask that you 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: _____

Hours per week mom works: _____ How often is mom out of town? _____

Father's occupation: _____

Father's Place of business: _____

Hours per week dad works: _____ How often is dad out of town? _____

Health Information

Was your child adopted? Yes No

Did the pregnancy go to full term? Yes No

Where there any complications with your pregnancy? Yes No

If so, what kind? _____

What illnesses has your child had (ear infections, etc.)? _____

Highest fever? _____ 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 a medical condition that requires immediate access to medication or a specific response from staff? * Yes No

Is your child sun sensitive? Yes No

Number of day's ill last year? _____

How old was your child when he/she started walking? _____

Did your child crawl before walking? Yes No

Age when first word was spoken? _____

Is your child taking any daily medications? 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, please explain: _____

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

How long does your child typically nap for? _____

And at what time(s)? _____

Does your child have frequent ear infections? Yes No

Does your child have tubes? Yes No

Family & Childcare Information

Does your child have any siblings? Yes No

Name	Age	Describe Relationship

Parents' marital status: _____

With whom does your child live? _____

Likes & Dislikes

What does your child enjoy doing the most at home? _____

When interacting with other children, how does your child react to conflict (crying, words, hitting, passive, etc.)? _____

Please describe, if any, difficulties that your child may have had in another school or group setting: _____

Routines (this will help us get a better understanding of what your child's typical day is like)

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

Are meals with adults? 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

Please describe your bedtime process: _____

Please describe your child's morning routine: _____

In what ways do you encourage independence in your child: _____

What brought you to Villa? _____

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