



Shomrei Torah Synagogue Early Childhood Education Center
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To Parents: Please fill out this record as completely as possible. The information will help us to know and understand your child, and enable us to better meet his/her needs. All such information will be considered confidential.

If you run out of space in any area, please use a separate attachment.

Today's Date ____/____/____	Child's Full Name: _____
Child's Present Age? ____ Yrs. ____ Mos.	Child's Date of Birth: ____/____/____
Mother's Name: _____	Age: ____ Occupation: _____ Health: _____
Father's Name: _____	Age: ____ Occupation: _____ Health: _____

Physical Development

At what age did your child: Crawl? _____ (mos.) Walk? _____ (mos.) Talk? _____ (mos.)

Was your child breast fed? _____ Until what age? _____ (mos.)

Was your child bottle fed? _____ Does your child still have a bottle? _____ Pacifier? _____

Bowel control established? _____ At what age? _____ (mos.)

Daytime bladder control established? _____ At what age? _____ (mos.)

Naptime bladder control established? _____ At what age? _____ (mos.)

Nighttime bladder control established? _____ At what age? _____ (mos.)

What word does your child use for urination? _____ For a bowel movement? _____

Does your child take responsibility for making bathroom needs known? _____

Currently, are there any special circumstances regarding bathroom habits? How do you handle them?

Does your child get frequent colds? _____ Has your child had any serious illnesses? _____

Has your child ever been hospitalized? _____ What were the circumstances? _____

How long? _____ How did your child react? _____

Sleep

At what time does your child usually go to bed? _____ Fall asleep? _____

Please describe a usual bedtime routine _____

Does your child sleep in his/her Own room? ___ Room shared with sibling? ___

Other? *Please explain* _____

Does your child sleep in his/her Own bed? ___ Crib? ___ Shares bed with? _____

Does your child sleep through the night? ___ How many hours of sleep? _____

How do you handle your child's waking in the night? _____

Do you have any concerns about your child's bedtime/sleeping routine? _____

Does your child nap? _____ Typically how long? _____

Please describe a usual nap routine? _____

What do you think will make your child's school nap more comfortable? _____

Physical Environment

Does your family live in a House? ___ Condominium? ___ Apartment? ___

Is there an area at home for toy storage? ___ Is there outdoor play area available? _____

How is your child encouraged to share the responsibility of putting away play things? _____

What does your child enjoy doing most? _____

What is/are your child's favorite toys, play materials, play activities? _____

Family Relationships

In what way do you participate in the daily care of your child? _____

Are there others (housekeeper, grandparent, older sibling) that live with you or participate in the daily care of your child? Please discuss their role. _____

Do you leave your child with a babysitter? _____ Is it generally the same person? _____

How does your child respond when left? _____

Are there opportunities for parent/child activities for fun, such as reading books, music, dance, etc.? Please describe these activities. _____

What opportunities for family time are routinely planned to which the child looks forward?

How does your child share in cooking and other housekeeping activities and responsibilities?

Does your child participate in family religious experiences? Please describe. _____

What do you like best about your child? _____

What do you find the most difficult? _____

What would you like your child to get out of his/her experience at STS ECEC? _____

Emotional Development

Does your child use a transitional object? Bottle ___ Pacifier ___ Special "blankie" ___
Doll ___ Other item _____

What does your child call the transitional object? _____

What time of day is your child likely to use the object? _____

If your child sucks his/her thumb or fingers, is there a particular time of day that is favored?

Does your child express emotion easily? _____

What makes your child angry? _____

How does your child express anger? _____

How are temper tantrums handled? _____

What type of things make your child sad? _____

How does your child express sadness? _____

What is your child fearful of? _____

What is your child sensitive to? _____

What is your child self-conscious about? _____

When is your child most comfortable? _____

What helps comfort your child is he/she is hurt or afraid? _____

Group Experiences

Have you and your child attended Parent/Infant or Parent/Toddler classes?

Program Name: _____ Dates Attended: _____

Program Name: _____ Dates Attended: _____

Has your child been in a childcare facility or school before?

Program Name: _____ Dates Attended: _____

Program Name: _____ Dates Attended: _____

Please describe the separation procedure and how you and your child responded to it.

Does your child enjoy Playing alone?___ Playing with other children?___ Being in a group?___

What are your child's favorite things to do? _____

Describe the way your child usually plays with other children. _____

Describe your child's reaction to adult help or direction. _____

Additional Information

List siblings

Name:_____ Age:_____ M:_ F:_ School_____ Health:_____ Living at home:_____

Name:_____ Age:_____ M:_ F:_ School_____ Health:_____ Living at home:_____

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Name:_____ Age:_____ M:_ F:_ School_____ Health:_____ Living at home:_____

Languages spoken at home: Primary:_____ Others:_____

Does your child let you know when he/she is hungry? _____ What foods does he/she dislike?_____

Does your child have any special food issues or habits we need to know about? How are they handled?
