



1556 First Ave., Suite B, Iowa City, IA 52240  
(319) 337-8922 (Local) (866) 537-8922

FORM: **Child Information Form**

PURPOSE: To be completed and submitted to Caring Hands & More (or UI Family Services) by guardian at least 3 day before first date of care.

Child's Full Name: \_\_\_\_\_  
(First Name) (Middle Initial) (Last Name)

Child's Birth Date: \_\_\_\_\_ (Ex: 1/1/2004)

**Family History**

Parents are (circle one): *Single* | *Married* | *Divorced* | *Separated* | *Other:* \_\_\_\_\_

Are you a faculty, staff, or student at the University of Iowa? *Yes* | *No*

*If you answered "Yes", please submit this form to the University of Iowa Family Services Office (121-50 USB)*

Please list other children in the home:

Name	Age	Name	Age
_____	_____	_____	_____
_____	_____	_____	_____

**Physical Regime**

Does your child have any diagnosed special needs? \_\_\_\_\_

If yes, please explain: \_\_\_\_\_

Does your child take any medications regularly that the Program will be giving to him/her? \_\_\_\_\_

Does your child have any unusual eating patterns or food dislikes? \_\_\_\_\_

Will your child need any accommodations or adaptations during meal times, snack time or playtime? \_\_\_\_\_

Does your family practice a religion that prevents your child from eating particular food(s)? If yes, please explain.

Does your child have any behaviors or special abilities that may give us cause to be concerned for the child's safety (i.e. can open outside doors; can open a baby gate or fence gate, runs from adults)? \_\_\_\_\_

What is your child's usual naptime? \_\_\_\_\_ Typical length of nap? \_\_\_\_\_

May we pat child's back to help to sleep or allow to fall asleep on own? \_\_\_\_\_

**If your child is an infant or toddler:**

Do you rock your child to sleep or just lay them down? \_\_\_\_\_

Do you allow your child to keep a pacifier in their mouth while sleeping? (circle one) *Yes* | *No*

Allow pacifier during the day, while awake? (circle one) *Yes* | *No*

*(This form was adopted by us and modified from forms created by The University of Iowa.)*



*Home Health Care & Family Services*

**Toileting**

How does your child state that he/she needs to go to the bathroom? (urination) \_\_\_\_\_

(bowel movement) \_\_\_\_\_

What type of assistance does your child need to use the restroom? \_\_\_\_\_

If your child is not an infant or toddler, does your child wipe him/her self? \_\_\_\_\_

**Personality and Emotional Development**

Does your child accept new people and new activities easily? \_\_\_\_\_

Does your child have any serious fears or anxiety times? \_\_\_\_\_

What comforts them during these times? \_\_\_\_\_

Describe your child's normal temperament: \_\_\_\_\_

\_\_\_\_\_

When you find it necessary to discipline your child, what technique works best? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Play and Socialization**

How does your child play alone and/or with other adults/children? \_\_\_\_\_

\_\_\_\_\_

What type of play activities does your child like to do or gives comfort to your child? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Are your child's playmates girls? \_\_\_\_\_ boys? \_\_\_\_\_ younger? \_\_\_\_\_ older? \_\_\_\_\_

Has your child previously attended a playgroup? \_\_\_\_\_ daycare? \_\_\_\_\_ preschool? \_\_\_\_\_

What was the usual size of the playgroup? \_\_\_\_\_

**Other Information**

Other information we should be aware of or that will be helpful to understanding your child: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

(If a newborn, please write as much as necessary to inform our staff about your child. Use back and extra paper if necessary.)

Guardian Signature

Printed Name

Contact Number(s)

Date

Guardian's Relation to Child: \_\_\_\_\_ (Ex. Mother, Father, etc.)

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