



**Health and Social Record  
Infant / Toddler**

Name \_\_\_\_\_

Birth Date \_\_\_\_\_

**Comforting**

Is there a time of day when your child feels irritable?     YES     NO

If "Yes" – Specify time \_\_\_\_\_

What techniques are used to help your child through this time?

Child likes to be:

Held     Sung to     Rocked     Read to     Other – Specify

Special things you say or do to comfort child.

**Sleep**

Current sleep schedule

Length of time on current schedule

If your child uses a pacifier, when do you usually offer it?

Falls asleep easily

YES     NO

Mood upon awakening – Describe

How does your child like to go down for a nap?

Held     Sung to     Rocked     Read to     Other – Specify

Takes favorite item to bed     YES     NO

If "Yes" – list

**Meals**

Current feeding schedule

Length of time on current schedule

Food type

Formula     Breast Milk     Strained     Junior     Table     Milk type – specify

New food timetable

When eating, child is –

Held in lap     In highchair     Other – Specify

Feeds self     YES     NO

If "Yes", uses -     Spoon     Fork     Hands

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**Meals cont.**

Is your child on a special or restricted diet, or have any food allergies (e.g. peanut butter)?  YES  NO

If "Yes" – Specify \_\_\_\_\_

Note: Please review SAUCC Handbook for restricted diet guidelines.

Favorite foods – Specify \_\_\_\_\_

Refused foods – Specify \_\_\_\_\_

**Diapering / Toileting**

Diaper – type

Cloth (must have Velcro fasteners and accompanied by plastic pants)  Disposable

Highly sensitive skin

YES  NO

Frequent diaper rash

YES  NO

Toilet training attempted

YES  NO If "Yes", describe routine \_\_\_\_\_

Type of toilet seat used at home

Potty chair  Special toilet seat  Regular toilet seat

Regular bowel movements

YES  NO How often - \_\_\_\_\_ Time(s) of day - \_\_\_\_\_

Toileting problems

YES  NO If "Yes" – Describe \_\_\_\_\_

**Medical**

Does your child have an existing condition of which the Children's Campus should be aware?  YES  NO

If "Yes" please explain \_\_\_\_\_

Does your child have any non-food allergies that the Children's Campus should be aware of (e.g. bee stings)?  YES  NO

Please explain \_\_\_\_\_

Does your child require any medication, therapy, medical treatment or assessment while in childcare?  YES  NO

Please explain \_\_\_\_\_

Does your child use any special equipment, such as breathing machine, wheelchair, hearing aid, braces, etc?  YES  NO

Please explain \_\_\_\_\_

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**Medical cont.**

Does your child require and/or desire any accommodations or modifications in order to fully and equally enjoy and participate in the Children's Campus group care setting?     YES     NO

Please explain \_\_\_\_\_  
\_\_\_\_\_

Has your child experienced a serious illness, convulsion, operation, or accident?     YES     NO

Please explain (include occurrence date) \_\_\_\_\_  
\_\_\_\_\_

**Miscellaneous**

Child's favorite toys and activities – Specify.

Indoors

Outdoors

By providing complete information about your child, you will be assisting teachers in creating a positive experience for him / her while in the Children's Campus program. List any information about your child's habits, abilities, or personality that you feel will be helpful to the teachers while caring for your child.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
**Signature of Parent or Legal Guardian**

\_\_\_\_\_  
**Date Signed**

**Enrollment Date** \_\_\_\_\_