RECTORY SCHOOL

Children At Rectory

INFANT • TODDLER • PRESCHOOL

CARe Parent and Child Information Sheet

Child's Name: _____Date of Birth: _____/_____/_____
Nickname to which child responds: _____ Home Tel. #: _____
Home Address: _____

Mother's Name: _____Occupation: _____
Place of Employment: _____
Home Address: _____ Home Tel. #: _____
Work Address: _____Work Tel. #: _____
Cell Tel. #: _____Email: _____

Father's Name: _____Occupation: _____
Place of Employment: _____
Home Address: _____Home Tel. #: _____
Work Address: _____Work Tel. #: _____
Cell Tel #: _____Email: _____

OTHERS LIVING IN THE HOME:

Name: _____ Age: _____ Relationship to Child: _____

Name: _____ Age: _____ Relationship to Child: _____

Name: _____ Age: _____ Relationship to Child: _____

Name: _____ Age: _____ Relationship to Child: _____

INTERESTS

What are your child's favorite toys? _____
What are your child's favorite activities? _____

Is there any other information about your child - special interests and/or fears; or ways that you give care - that would be helpful for our teachers to know in order to take better care of your child? Please tell us...

_____
_____
_____

528 POMFRET STREET POMFRET, CT 06258 TEL. (860) 928-1808 FAX (860) 928-1591 EMAIL children@rectoryschool.org

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FEEDING

Does you child have any food allergies? **No _____ Yes _____**

If "Yes", which foods?_____

Has your child had any feeding problems? No _____ Yes _____
If "Yes", describe: _____

Can your child eat with a spoon? No _____ Yes_____
Can your child eat with a fork? No _____ Yes_____
Can your child cut with a plastic knife? No _____ Yes_____
Does your child have a good appetite? No _____ Yes_____

What are your child's favorite foods?

_____

What foods does your child dislike?

_____

FOR INFANTS: Is your baby breast or bottle-fed? _____
What food is your baby eating right now?

Fruits_____Juices_____Veggies_____Meats_____Cereals_____Milk/Formula_____

SLEEPING

Has your child had any sleeping problems? No _____ Yes_____

If "Yes", describe: _____

How long does your child usually sleep at night? _____

Does your child nap during the day? AM _____ PM _____

Do you have any special ways of helping your child get to sleep? _____

Does your child like a special object at naptime? _____

Does your child sleep in a crib or bed? _____

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HEALTH

Has your child ever had a serious illness? No _____ Yes_____

If "Yes", please describe: _____

Has your child ever had any operations? No _____ Yes_____

If "Yes", please describe: _____

Does your child take any medication daily? _____

If "Yes", what, and why? _____

Does your child have any special needs? No _____ Yes _____

If "Yes", please describe: _____

Is your child now or did he/she ever receiving services from any organization or consultant?
If "Yes", when and who? _____

If "Yes" please share any test results that address your child's academic or psychological needs. _____
_____

Has your child ever visited the dentist? No _____ Yes _____

Has your child had any of the following?

Whooping cough:	No_____Yes_____	Mumps:	No_____Yes_____
Measles:	No_____Yes_____	Rubella:	No_____Yes_____
Chicken pox:	No_____Yes_____	Pneumonia:	No_____Yes_____
High Fever (over 103):	No_____Yes_____	Seizures:	No_____Yes_____
Allergies:	No_____Yes_____	Eczema:	No_____Yes_____
Serious Injuries:	No_____Yes_____	Other:	_____

Please elaborate on any conditions for which you checked "yes", or anything you feel should be brought to the attention of the CARe teachers or Nurse Consultant:

_____
_____
_____
_____
_____
_____

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