ADDITIONAL INFORMATION

GROUP EXPERIENCES

WHAT IS/ARE YOUR CHILD'S FAVOURITE TOY(S)/ACTIVITIES?
HAS YOUR CHILD HAD PREVIOUS PLAY GROUP EXPERIENCE? YES ☐ NO ☐ IF YES, HOW DID HE/SHE ADAPT?
HOW DOES YOUR CHILD BEHAVE TOWARD OTHER CHILDREN [E.G., SEEKS OTHERS OUT, FEELS SHY]:

EMOTIONAL

HOW DOES YOUR CHILD REACT WHEN LEFT WITH UNFAMILIAR PEOPLE AND/OR IN UNFAMILIAR SITUATIONS?
DOES YOUR CHILD HAVE ANY PARTICULAR FEARS? PLEASE DESCRIBE:
WHAT SUGGESTIONS DO YOU HAVE THAT WOULD HELP STAFF TO MAKE YOUR CHILD'S TRANSITION INTO THIS PROGRAM EASIER?
PLEASE LIST THE NAMES OF THE SIGNIFICANT PEOPLE IN YOUR CHILD'S LIFE [E.G., SIBLINGS, GRANDPARENTS, ETC.]:
PLEASE DESCRIBE THE GUIDANCE AND DISCIPLINE METHODS USED AT HOME:
PRIMARY LANGUAGE SPOKEN IN THE HOME: OTHER LANGUAGES:
NAME OF ENGLISH SPEAKING PERSON [IF NEEDED]: PHONE:

SIGNATUREEATING AND NUTRITION

LIST YOUR CHILD'S FAVOURITE FOOD:
LIST ANY DISLIKED FOOD:
PLEASE DESCRIBE ANY PARTICULAR EATING PATTERNS:
ARE THERE ANY RELIGIOUS OR ETHNIC OBSERVANCES RELATED TO FOODS:

SLEEPING

NAP TIME: HOW LONG TO SETTLE TIME OF WAKING:
BEDTIME: HOW LONG TO SETTLE TIME OF WAKING:
IS YOUR CHILD A DEEP SLEEPER, OR DOES (S)HE AWAKEN EASILY?
DOES YOUR CHILD TAKE A FAVOURITE COMFORTER [E.G., BLANKET OR TOY] TO BED? IF YES, PLEASE DESCRIBE AND TELL US IF IT IS "NAMED": YES ☐ NO ☐
WHAT IS YOUR CHILD'S MOOD UPON WAKENING?

TOILETING

IS YOUR CHILD TOILET-TRAINED? YES ☐ NO ☐ PARTIALLY ☐
PLEASE INDICATE YOUR CHILD'S FREQUENCY OR PATTERNS FOR BOWEL MOVEMENTS:
DESCRIBE ASSISTANCE NEEDED FOR TOILETING:
WHAT "SPECIAL" WORD DOES YOUR CHILD USE FOR: URINATION: BOWEL MOVEMENTS

Signature of Parent/Guardian