Peace of Mind's Home Environment and Social Development

Child(rens) Name(s): _____
(May list more than one child as long as info is complete for all children)

List brothers and sisters:

Name	Sex	Date of Birth

Who lives in the home with your child?

Name	Relationship

What is the primary language spoken in your home?

How does your family define your family culture, race, and religion?

What special family traditions, values or beliefs do you practice in your home?

How often does your child play with friends? **(Daycare, Sunday school, athletics, dance, etc.):**

Describe your child's experience with other children:

Medical history

Allergies: Please list any TRUE allergies to food, medication or other (bees, etc.)

Food	Medicinal or Other

Do you have any special diet preferences that are not true allergies (i.e. no dairy, vegetarian, gluten free)? Is so please request a food preference form (Note: Peace of Mind may request a physician's note in order to accommodate certain food preference requests). Allergies also require a separate physician statement. Both of these forms are available at the front desk.
NOTE: We make reasonable accommodations for preferences but may not be able to meet every request. We are required to follow USDA recommendations, and the recommendations of our health needs with regards to children's meals, and must comply with these rules even if a parent has a a special request.

Note: Peace of Mind is happy to honor and accommodate most special diet requests. For milk substitutions, such as almond, rice or goats milk substitute, a doctor's note is required for children under two years of age. (We serve whole cow's milk).

Is your child on any regular medications? YES or NO and if yes, please list the medications they take & the reason they take them:

If yes, how does the medication alter your child's behavior?

Has child had any surgery or bone fractures?

Has a physician ever been consulted with regards to speech, hearing or vision problems?

Are there any health problems in the family? Please describe how it may affect your child. (I.e. parent has a chronic illness, or grandparent or sibling illnesses)

Has your child had any contagious diseases? If yes, please list:

Tell us a little about your child. In what particular ways can we help your child this year? List a couple of goals, and we will discuss this further at conferences.

Sleep Routine

Length of time_____ Regular nap schedule:_____
(hours and minutes)

- ❒ My child no longer takes naps _____(please initial)
  (Note: we do ask kids to be quiet/still on a cot until the summer before Kindergarten. Thirty minutes of quiet time is expected and then kids who do not sleep may get up off their cots and participate in activities).

Night time Routine: In bed at:_____p.m.

Asleep at:_____p.m.

Up around:_____a.m.

Toilet Training

Is your child potty trained? (Please circle): YES or NO

Note: POM charges the toddler rate until kids go two weeks "accident free" and completely diaper free (even at nap). The first of the month following this two week period, we drop to the preschool rate. POM does not provide or recommend the use of pull-ups, but rather, prefers to support kids/parent in going right from diapers to underwear.

What does child say for urination? Bowel movement?

Behavioral Tendencies

Do you have any concerns about your child's behavior?

Has anyone else ever raised any potential concerns regarding your child's behavior?

What redirection practices are used in the home?

Anything else you think would be helpful in caring for your child?