



Family Profile Form

Please complete this form in its entirety.

FOR OFFICE USE ONLY

Start Date: _____
End Date: _____

CHILD'S INFORMATION

Child's Name _____ Date of Birth _____ Gender: Male Female
 Name/Nickname to Call Child _____ Name you would like on coat hook/mailbox _____
 Child's Class _____ Days of Week _____
 Home Address _____ City _____ Zip _____
 Home Phone _____ Alternate Phone _____
 Who should we contact in an emergency? Name _____ Phone _____
 Who has legal custody of child? _____ Any restrictions? _____

YOUR FAMILY

Parents' Marital Status/Date: Single Married _____ Widowed _____ Separated _____ Divorced _____

PARENT/GUARDIAN #1: Name _____

Occupation _____

Would you be willing to share your occupation with your child's class during Community Helpers Month? _____

Health Problems? _____

Address if different than above _____

Business Name and Address _____

Business Phone _____ Cell Phone _____

Work Days/Hours: Mon _____ Tues _____ Wed _____ Thurs _____ Fri _____ Sat _____ Sun _____

Do you travel for business? If yes, how often? _____

PARENT/GUARDIAN #2: Name _____

Occupation _____

Would you be willing to share your occupation with your child's class during Community Helpers Month? _____

Health Problems? _____

Address if different than above _____

Business Name and Address _____

Business Phone _____ Cell Phone _____

Work Days/Hours: Mon _____ Tues _____ Wed _____ Thurs _____ Fri _____ Sat _____ Sun _____

Do you travel for business? If yes, how often? _____

Other children in Family:

Name	Date of Birth	Resides With	Health	School/Grade	Gender
_____	_____	_____	_____	_____	<input type="radio"/> M <input type="radio"/> F
_____	_____	_____	_____	_____	<input type="radio"/> M <input type="radio"/> F
_____	_____	_____	_____	_____	<input type="radio"/> M <input type="radio"/> F
_____	_____	_____	_____	_____	<input type="radio"/> M <input type="radio"/> F

What cultural holidays does your family celebrate? _____

Would you be willing to share these holidays with your child's class? _____

Are there other adult(s) living in home? _____ Relationship? _____

Type of family pet(s)/Name(s) _____

Languages spoken at home _____

Is there a caregiver other than parent/guardian? Yes No Relationship? _____

Does caregiver live in child's home? If yes, how long has caregiver been with family? _____

What activities does caregiver do with child? _____

Has your child been left with a sitter? If yes, how often? _____

Child's reaction? _____

Have there been any recent family changes?

Move to new home _____ Change in caregiver _____

New job _____ Death in family _____

New hours at work _____ Loss of pet _____

New baby _____ Other loss _____

Serious illness _____ Other _____

What was child told about change(s) in family? _____

How did s/he react? _____

YOUR CHILD

How does your child handle changes in routine? _____

How does s/he react in new situations? _____

Please note specific situations in which your child tends to become upset, angry, scared, withdrawn or other _____

Describe how you help your child handle these situations _____

How would you describe his/her temperament/personality? _____

What three adjectives would you use to describe your child? _____

Describe your approach to discipline and how your child responds _____

What are your child's play habits? _____

Does s/he make friends with other children easily or cautiously? _____

Does s/he show interest in other adults easily or cautiously? _____

How would you describe your child's attitude toward other adults? Friendly Aggressive Shy Indifferent

How would you describe your child's play? Active Boisterous Quiet Self-initiated

Does your child have playmates? If yes, how many? _____ Gender? _____

How does s/he interact with playmates? _____

How does s/he get along with siblings? _____

What does s/he enjoy doing with other members of family? _____

Does s/he have any special interests or hobbies? _____

Are there special family times and/or excursions s/he enjoys? _____

PRENATAL & POSTNATAL

Did mother have any illnesses or take medications during pregnancy? _____

Was pregnancy: Full term Premature Child's weight at birth _____ Child's length at birth _____

Were there any complications after birth? _____

Did you receive anesthesia or medication during delivery? _____

As a baby, was your child: Easy going Active Colicky Other _____

GENERAL HEALTH/MEDICAL INFORMATION

Child's Physician _____ Phone _____

Child's Dentist _____ Phone _____

Hospital Affiliation _____

Were or are there any physical or medical factors of which we should be aware?

Allergies _____

Vision _____

Hearing _____

Ear infections? How often? _____ Fluid? Yes No

Coordination _____

Constipation _____

Diarrhea _____

Other _____

Does your child use adaptive equipment, medical or health equipment (tubes, glasses)? If yes, please describe _____

Does your child take medication regularly? If yes, please describe _____

Are there special instructions for this medication? _____

Has your child ever experienced:

Serious illness _____ Type/reason _____ Date _____

Hospitalization _____ Type/reason _____ Date _____

Surgery _____ Type/reason _____ Date _____

Accident(s) _____ Type/reason _____ Date _____

Injuries _____ Type/reason _____ Date _____

Other _____

CHILDCARE ROUTINES

Is this your child's first preschool experience? Yes No

If no, what was previous experience? _____

Where? _____

How long did s/he participate? Days/Week _____ Hours/Day _____

What was his/her reaction? _____

Why did this experience end? _____

Are/were there any other group experiences? _____

Will your child participate in other programs this year? If yes, which ones? _____

_____ With or without an adult? _____

Does s/he know other children who are attending Little Ones? If yes, please list name(s) _____

What experiences would you like your child to have in preschool this year? _____

SLEEPING

Does your child:

Go to sleep with difficulty? If yes, how do you handle it? _____

Use a bottle _____

Use a pacifier _____

Suck thumb _____

Sleep in a crib _____

Sleep in a bed _____

Sleep alone _____

Sleep with a toy _____

Sleep with a blanket _____

Have nighttime rituals _____

Have nighttime fears _____

What time does your child usually go to bed? _____

What time does s/he usually wake up? _____

Does your child nap? If yes, what time/how long? _____

Any other information about sleeping? _____

DEVELOPMENT

At what age did your child: Crawl _____ Walk _____ Point _____

Babble _____ Use single words _____ Use phrases _____

What were first words? _____

What were first phrases? _____

At what age did your child start potty training? B.M. _____ Bladder _____

Method of training _____ Does s/he tell you: Before After

Does s/he need to be reminded to go? During the day: Yes No At night: Yes No

Does s/he mind using unfamiliar toilets? Yes No

If s/he has an accident, what is his/her reaction? _____

Are mealtimes: Pleasant Difficult Please describe _____

What are your child's favorite foods? _____

What foods does your child dislike? _____

When does s/he get hungry? _____

How often does your child eat during the day? _____

Are there any aspects of your child's development that are of concern to you? _____

Do you feel that collaboration would be useful? Yes No

What particular things would you like us to work on together during the year? _____

OTHER

Is there any other information that you would like to provide? _____

Are there any programs or services not provided by Little Ones that you would like us to consider? _____

SIGNATURE

Signature of Parent/Guardian _____ Date _____

Email _____

Thank you for completing this form!
The information you provided will allow the staff at Little Ones to
provide caring, individualized attention for your child.
If you have any questions about this form, please don't hesitate to call.

Little Ones Preschool, Inc.
3433 Walters Avenue • Northbrook, IL 60062
phone 847-272-4646 • fax 847-715-0971 • www.littleones-preschool.com
