



# Leech Lake Early Head Start Classroom Information



Early Head Start would like to get to know your child better, please fill in the following information.

**Child's Name:** \_\_\_\_\_ **Nick Name:** \_\_\_\_\_

**Birthday:** \_\_\_\_\_ Does your child separate easily from you? Yes No

Has your child stayed with anyone else besides you? Other child care Programs? If so, who and please describe these experiences: \_\_\_\_\_

\_\_\_\_\_

Does your child have siblings? Name and ages: \_\_\_\_\_

\_\_\_\_\_

Is there anything about your child or has anything happened to your child that we should be aware of? (Example: recent move, separation from caregiver, etc.) Explain: \_\_\_\_\_

\_\_\_\_\_

Is your child currently receiving Special Education Services such as: IEP \_\_\_ IFSP \_\_\_ Other \_\_\_

Do you have any concerns about your child's development or behaviors? Yes No

If yes, please comment: \_\_\_\_\_

Age your child begin to: Sit \_\_\_\_\_ Crawl \_\_\_\_\_ Walk \_\_\_\_\_ Talk \_\_\_\_\_

Any difficulties with speech? Yes No

If yes, please specify: \_\_\_\_\_

What are some of your child's favorites? (toys, songs, activities) \_\_\_\_\_

\_\_\_\_\_

How does your child play: (Check all that apply)

Mostly Alone \_\_\_ With others \_\_\_ Plays well with others \_\_\_ Bossy \_\_\_ Aggressive \_\_\_ Shares well \_\_\_

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

\_\_\_\_\_

What is something that provides comfort/security for your child? (pacifier, toys, blanket, etc.) \_\_\_\_\_

\_\_\_\_\_

What makes your child frustrated, upset, or afraid? \_\_\_\_\_

\_\_\_\_\_

Describe your child's basic personality (good natured, clingy, fussy, etc.): \_\_\_\_\_

\_\_\_\_\_

Please describe a typical day with your child: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Does your child have a spirit name? \_\_\_\_\_

What is your child's Clan? \_\_\_\_\_

**Sleeping:** Note: All infants will be placed on their back when being put to sleep.

When does your child wake up in the morning?

AM Nap: From \_\_\_\_\_ To \_\_\_\_\_ PM Nap: From \_\_\_\_\_ To \_\_\_\_\_

When going to sleep, what does your child need: Pacifier\_\_\_ Blanket\_\_\_ Other:\_\_\_\_\_

Does your child usually cry or become upset when going to sleep? Yes No

Describe ways to help your child go to sleep: \_\_\_\_\_  
\_\_\_\_\_

What is your child's disposition upon waking up? \_\_\_\_\_  
\_\_\_\_\_

### **Diapering/Potty Training**

Is your child potty trained? Yes No

If not, please describe your child's diapering routine: \_\_\_\_\_  
\_\_\_\_\_

If your child is using the toilet, what are you using (Please circle one): Pull-ups Underwear

What words does your child use for the bathroom? \_\_\_\_\_

How many times a day does your child have a bowel movement? Once Twice More:\_\_\_\_\_

Is the bowel movement usually: Solid Normal Diluted

How do you treat diaper rash? \_\_\_\_\_

Do you have products or brands you do not want used on your child? \_\_\_\_\_

Is there anything else you would like us to know that would help us better understand your child? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Teachers: Keep this form for the child's classroom file