

"Getting to Know You" Survey

Child's Name: _____ Date: _____
Nickname: _____ (if applicable)

Family Member	Relationship
1)	
2)	
3)	
4)	
5)	

Ages of siblings: _____

What are your child's favorite toys? _____

Has your child been separated from you before? Yes _____ No _____

If yes, please describe circumstances _____

Does your child exhibit any fears? Yes _____ No _____

If yes, please explain _____

What do you hope your child will gain from his/her experience in group care?

Does your child have any allergies? Yes _____ No _____

If yes, please describe _____

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Feeding Information

Preferences	Yes	No	Special Instructions
Warm Bottle			
Warm Food			
Feeds Self			
Uses Spoon			
Feeding Table			

Diapering Information

Condition	Ointment	Lotion	Powder	Special Instructions
Wet				
BM				
Rash				

Sleeping Preferences:

Position: Back Side Pacifier: Yes No

Special Blanket: Yes No Special Toy: Yes No

Current Sleeping Schedule: _____

Is there anything else you would like us to know? _____

MONTHLY FEEDING AND HABITS INSTRUCTIONS

MONTH

DATE

NAME

AGE IN MONTHS

BIRTHDAY

BOTTLES: TIMES & PREPARE

FOOD: TIMES & PREPARE

SLEEPING HABITS

IF CHILD IS UPSET WHAT WORKS TO CALM CHILD DOWN??

ADDITIONAL INSTRUCCIONS:

PARENT SIGNATURE

DATE