CAPS Care Intake Form - Over 2 Years

Child's Name:______________________________ Date of Birth:__________________ Gender: ___M ___ F

Eating

Is your child on a special diet? ___ Vegetarian ___Vegan ___Dairy-Free ___Other:____________________

Does your child have any food allergies? Yes or No If yes, please describe:_________________________

What does your child use to drink?

___ Bottle ___ Sippy Cup ___ Regular Cup ___ Nursing ___ Other:________________________________

*At CAPS Care we will not give a child a bottle unless we have a doctor's note stating the child needs it

What time does your child eat their meals? Put n/a if they do not have that meal.

Breakfast: _____ AM Snack:_____ Lunch:_____ PM Snack:_____ Supper:_____ Other:_____

What does your child sit in to eat meals? ___High Chair ___Booster Seat ___Adult Sized Chair

Are there any foods they refuse to eat? ____

Sleeping

Does your child nap? Yes or No How many times per day?_____ How long?______________________

Does your child sleep with a special blanket, toy, pacifier, or "lovey"? Yes or No

If yes, which one? ____________

*At CAPS Care we prefer not to let children have pacifiers in the toddler room for safety reasons.

Are there any specific bedtime routines at home that we should know about? __________________________

____.

Toileting

Does your child use diapers? Yes or No ___Cloth ___Disposable ___Pull Ups

*If cloth, remember we do not launder diapers and they will be bagged up and sent home.

Are you potty training at home? Yes or No Do they use a potty or the toilet?_________________________

How does your child let you know it's time "to go"?____

Does your child need regular reminders to go to the bathroom? Yes or No

Does your child get frequent diaper rash? Yes or No

What diaper cream, powders, or salves do you use? ____

What is your child's primary spoken language? ____

Are there other languages being used with your child? ____

Additional Comments: ____

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Parent Signature:____ Date: _______________________