

# Play & Learn



## Toddler Profile

Child's Name: \_\_\_\_\_

Center: \_\_\_\_\_

Program: \_\_\_\_\_

"Getting to Know You" Date: \_\_\_\_\_

# Play & Learn

A cartoon illustration of a young girl with red hair in pigtails, wearing a yellow dress, standing on a stack of five colorful books. She has her arms raised in a happy gesture.

Dear Parents,

Welcome to Play & Learn! In order to better understand your child, we have designed this booklet to allow you to share information concerning your child's personal habits, skills, and health. This profile will give us a "head start" in attaining our goal of meeting your child's needs. Feel free to include any additional information and concerns.



## GENERAL INFORMATION

Child's Full Name: \_\_\_\_\_

Nickname: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_

Parent Names: \_\_\_\_\_

\_\_\_\_\_

If child is not in care of parents, please list guardian name(s):

\_\_\_\_\_

\_\_\_\_\_

What is the marital status of parents?

\_\_\_\_\_ Married    \_\_\_\_\_ Divorced    \_\_\_\_\_ Separated    \_\_\_\_\_ Single

Are both parents living in the house with the child?    \_\_\_\_\_ Yes    \_\_\_\_\_ No

Please list all siblings:

Name

Age

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please list anyone else living in the house with the child:

Name

Relationship

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Who will be dropping off your child? \_\_\_\_\_

Who will be picking up your child? \_\_\_\_\_

## SELF HELP SKILLS

### Sleeping

Does your child nap? \_\_\_\_\_ Yes \_\_\_\_\_ No

Please list your child's napping hours: \_\_\_\_\_

Does your child wear a diaper at naptime? \_\_\_\_\_ Yes \_\_\_\_\_ No

Please list any important napping habits: \_\_\_\_\_

\_\_\_\_\_

### Feeding

Does your child drink from a cup? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, can your child drink from a cup with or without assistance? \_\_\_\_\_

\_\_\_\_\_

Describe your child's feeding habits and need for assistance: \_\_\_\_\_

\_\_\_\_\_

### Dressing

Please describe your child's dressing needs: \_\_\_\_\_

\_\_\_\_\_

### Toileting

Does your child wear diapers? \_\_\_\_\_ Yes \_\_\_\_\_ No

Please describe your child's toileting habits and need for assistance: \_\_\_\_\_

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What words does your child use to communicate toileting needs? \_\_\_\_\_

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## PLAY SKILLS

What does your child enjoy doing/playing? \_\_\_\_\_

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How does your child get along with other children? \_\_\_\_\_

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## COMMUNICATION SKILLS

How does your child express his or her needs? \_\_\_\_\_

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Can you understand your child's speech? \_\_\_\_\_ Yes \_\_\_\_\_ No

Can others understand your child's speech? \_\_\_\_\_ Yes \_\_\_\_\_ No

Comments: \_\_\_\_\_

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Please list any unusual words that your child uses to communicate: \_\_\_\_\_

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Please describe how your child listens and follows directions: \_\_\_\_\_

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## PERSONAL CHARACTERISTICS

Circle the characteristics that seem to describe your child:

Tense	Sad	Happy	Sensitive	Creative
Relaxed	Outgoing	Energetic	Caring	Quiet
Frustrated	Demanding	Stubborn	Cooperative	

How does your child generally react to new experiences? \_\_\_\_\_

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Does your child have any unusual fears? \_\_\_\_\_

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How does your child react to a frustrating situation? \_\_\_\_\_

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## MEDICAL INFORMATION

Please provide information if your child has a history of any of the following conditions:

	Date	Circumstances
Allergy	_____	_____
Asthma	_____	_____
Concussion	_____	_____
Convulsions	_____	_____
High Fevers	_____	_____
Seizures	_____	_____
Serious Falls	_____	_____
Serious Injury	_____	_____
Chronic Illness	_____	_____

Hospitalization \_\_\_\_\_

Other \_\_\_\_\_

Describe any history of visual problems: \_\_\_\_\_

\_\_\_\_\_

Describe any history of hearing problems: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### **Medication**

Please list your child's current medication(s): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please list the condition(s) that the medication(s) treat: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please list any other current medical issues: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

How would you describe your child's general health? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



Please describe any physical handicaps or limitations: \_\_\_\_\_

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Please describe any special dietary needs and/or food allergies: \_\_\_\_\_

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Are there any special concerns that we need to know? \_\_\_\_\_

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Are any early intervention services provided for your child? If yes, please describe: \_\_\_\_\_

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Please provide your center director with IFSP or IEP documentation if applicable.

Please describe any helpful hints that will enable us to best work with your child: \_\_\_\_\_

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