

# Child Portrait

Please complete and return to the center by your child's first day of attendance. This will assist staff in getting acquainted with your child and in helping your child adjust.

Date: \_\_\_\_\_ Person completing form: \_\_\_\_\_

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

## Children in Family/Household

## Children's ages

- |          |       |
|----------|-------|
| 1. _____ | _____ |
| 2. _____ | _____ |
| 3. _____ | _____ |
| 4. _____ | _____ |
| 5. _____ | _____ |

## Others in Family/Household

## Relationship

## Occupation

- |          |       |       |
|----------|-------|-------|
| 1. _____ | _____ | _____ |
| 2. _____ | _____ | _____ |
| 3. _____ | _____ | _____ |
| 4. _____ | _____ | _____ |
| 5. _____ | _____ | _____ |

1. Does your child prefer playing alone? \_\_\_\_\_ with other children? \_\_\_\_\_ List names of favorite playmates:

2. What is your child's most favorite toy? \_\_\_\_\_

Most favorite activity? \_\_\_\_\_

3. List your child's pets \_\_\_\_\_

Names of pets? \_\_\_\_\_

4. Has your child attended any children's groups such as Day Care? \_\_\_\_\_ Sunday School? \_\_\_\_\_

Vacation Bible School? \_\_\_\_\_ Nursery School? \_\_\_\_\_ Other? \_\_\_\_\_

5. What method of control, discipline, teaching do you find most effective? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

6. Is there anything in particular which frightens your child? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

7. Has your child had severely upsetting experiences such as divorce of parents, death in family, frequent or recent moves, etc? \_\_\_\_\_  
\_\_\_\_\_

What were his/her reactions? \_\_\_\_\_  
\_\_\_\_\_

8. As a rule, is your child's appetite excellent? \_\_\_\_\_ good? \_\_\_\_\_ fair? \_\_\_\_\_ poor? \_\_\_\_\_

9. List foods not allowed to eat \_\_\_\_\_

10. Favorite foods \_\_\_\_\_

11. Disliked foods \_\_\_\_\_

12. Is toilet control established at daytime? \_\_\_\_\_ during night? \_\_\_\_\_

13. How does your child indicate need for urination? \_\_\_\_\_  
bowel movement? \_\_\_\_\_

14. Describe any difficulties observed with your child's:

Hearing \_\_\_\_\_

Vision \_\_\_\_\_

Other \_\_\_\_\_

15. Other information you feel might be helpful in working with your child in the center (including but not limiting cultural customs, home languages, religious observances, ethnicity, etc.): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_