**INTAKE FOR CHILD UNDER 2 YEARS – CHILD CARE CENTERS**

**Use of form:** This form is mandatory for family child care centers to comply with DCF 250.09(1)(c)1. and for certified providers to comply with 202.08(12)(g). Failure to comply may result in issuance of a noncompliance statement. This form is voluntary for group child care centers; however, it meets the requirements of DCF 251.09(1)(am). This form collects information about children under 2 years of age in order to aid child care workers in individualizing the program of care for the child in a family or group child care center. Personal information you provide may be used for secondary purposes [Privacy Law, s.15.04(1)(m), Wisconsin Statutes].

**Instructions:** This form is to be completed by a parent / guardian and must be on file at the center prior to a child's first day of attendance. Regular updates can be noted. This form should be kept in the room where care is provided. If additional space is needed, attach a separate sheet.

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|  | | | First Day of Attendance (mm/dd/yyyy) | | | |
| **PARENT / CHILD NAME AND ADDRESS** | | | | | | |
| Name – Child (Last, First, MI) | | Nickname (If any) | | | | Birthdate (mm/dd/yyyy) |
| Name – Parent(s) (Last, First, MI) | | | | | Telephone Number – Home | |
| Address – Parent(s) (Street, City, State, Zip Code) | | | | | | |
| **HEALTH** Note: Health conditions that may affect the care of the child must be recorded on the department’s form, *Health History and Emergency Care Plan*. The form should be shared with any person who provides care for the child. | | | | | | |
|  | Child has frequent colds, ear infections, colic, etc. – Describe. | | | | | |
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| UPDATES | | | | | | |
| **MEALS** | | | | | | |
| Current feeding schedule | | | | Length of time on current schedule | | |
| Food type  Breast milk  Formula  Strained  Junior  Table  Milk type – Specify: | | | | | | |
| New food timetable | | | | | | |
| When eating, child is –  Held in lap  In highchair  Other – Specify: | | | | | | |
| Feeds self  Yes  No If "Yes", uses:  Spoon  Fork  Hands | | | | | | |
| Special feeding problems  Yes  No If "Yes" – Specify: | | | | | | |
| Food allergies  Yes  No If "Yes" – Specify: | | | | | | |
| Favorite foods – Specify. | | | | | | |
| Refused foods – Specify. | | | | | | |
| UPDATES | | | | | | |

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| **SLEEP** | | | | | |
| Current sleep schedule | | | | | Length of time on current schedule |
| Falls asleep easily  Yes  No | Mood upon awakening – Describe. | | | | |
| Takes favorite toy(s) to bed – **child** **over age 1 year**  Yes  No If "Yes" – list toy(s): | | | | | |
| Sleep position – **child under age 1 year**  **Note:** Children under age 1 year must be placed to sleep on their back unless a written statement from the child's physician is attached.  Back for children under age 1 year  Side or stomach (physician statement attached) | | | | | |
| Sleep position – **child age 1 year and older**  Back  Side or stomach | | | | | |
| UPDATES | | | | | |
| **DIAPERING / TOILETING** | | | | | |
| Diaper – type  Cloth  Disposable | | Diapers provided by parent  Yes  No | | | |
| Plastic pants used  Always  Never  Sometimes If "Sometimes" – Specify: | | | | | |
| Highly sensitive skin  Yes  No | | Frequent diaper rash  Yes  No | | | |
| Lotions, powders, or salves used  Yes  No If "Yes", product name(s) – Specify: | | | | | |
| Toilet training attempted  Yes  No If "Yes", describe routine. | | | | | |
| Type of toilet seat used at home  Potty chair  Special toilet seat  Regular toilet seat | | | | | |
| Regular bowel movements  Yes  No How often: | | | | Time(s) of day: | |
| Toileting problems  Yes  No If "Yes" – Describe. | | | | | |
| UPDATES | | | | | |
| **VERBAL COMMUNICATION** | | | | | |
| Family’s spoken language.  English  Spanish  Other If "Other" – Specify: | | | | | |
| Age child began talking | | | Child speaks in  Words  Sentences | | |
| Words used to describe special needs – Specify. | | | | | |
| UPDATES | | | | | |

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| **COMFORTING** |
| Does child have a fussy time?  Yes  No If "Yes" – Specify time. |
| How is fussy time handled? |
| Child likes to be:  Held  Sung to  Rocked  Read to  Other – Specify: |
| Special things you say or do to comfort child. |
| UPDATES |
| **SELF-EXPRESSION** |
| What causes your child to feel angry or frustrated? |
| What frightens your child and how is it shown? |
| How does your child express feelings of happiness, enjoyment, etc.? |
| Additional comments |
| UPDATES |

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| **PHYSICAL AND SOCIAL DEVELOPMENT** | | | | |
| Is your child able to – (Check all that apply) | | | | |
| Sit up alone  Pull up  Crawl  Walk holding on  Walk without support | | | | |
| Yes  No Is your child used to playmates? | | | | |
| Comments | | | | |
| UPDATES | | | | |
| **MISCELLANEOUS** | | | | |
| Child's favorite **indoor** toys and activities – Specify. | | | | |
| Child's favorite **outdoor** toys and activities – Specify. | | | | |
| By providing complete information about your child, you will be assisting staff in creating a positive experience for him / her while in care. List any information about your child's habits, abilities, or personality that you feel will be helpful to the staff while caring for your child. | | | | |
| UPDATES | | | | |
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|  | **SIGNATURE** – Parent or Guardian |  | Date Signed |  |