

Toddlers Profile Form

Bumper Bears Early Learning Centre

Name:	
Date of Birth:	
Dietary/health issues:	
Other information:	
(eg usual drop off/pick up times)	

Toileting			
Is your child?	<input type="checkbox"/> In daytime nappies?	<input type="checkbox"/> In process of toilet training?	<input type="checkbox"/> Independently toilet trained?
Does your child like sitting on?	A potty? <input type="checkbox"/> Yes <input type="checkbox"/> No	A toilet? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Does your child use any special word or sign for toilet?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, what is this?	

Sleeping	
Does your child sleep well at night?	<input type="checkbox"/> Yes <input type="checkbox"/> No
What is their day time sleep pattern, including any comfort routines or items?	

Communication	
Does your child use gestures and sounds to communicate?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is your child using words to communicate?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is your child talking in more than three (3) word sentences?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you speak another language other than English at home?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, what language do you speak at home?	
Have you any concerns about your child's speech?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, what are your concerns?	

Is your child?	Walking	<input type="checkbox"/> Yes <input type="checkbox"/> No	Running	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Sitting in chair	<input type="checkbox"/> Yes <input type="checkbox"/> No	Standing	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Climbing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Falling Often	<input type="checkbox"/> Yes <input type="checkbox"/> No
Will your child sit for?	A Story	<input type="checkbox"/> Yes <input type="checkbox"/> No	Singing	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Mealtime	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Parent/Guardian Signature: _____

Date: _____