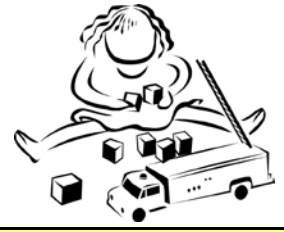




Gertrude Remmel Butler  
**CHILD DEVELOPMENT CENTER**  
 Of First United Methodist Church



**Child Bio**

In order for your child's teacher to know your child better, we ask that you complete this form and return it to the Child Development Center. **Please Print**

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

Nick Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Mother's Name: \_\_\_\_\_

Mother's Workplace: \_\_\_\_\_

Father's Name: \_\_\_\_\_

Father's Workplace: \_\_\_\_\_

Child lives with:

- Both parents \_\_\_\_\_
- Mother Only \_\_\_\_\_
- Father Only \_\_\_\_\_
- Mother / Stepfather \_\_\_\_\_ (Stepfather's name) \_\_\_\_\_
- Father / Stepmother \_\_\_\_\_ (Stepmother's name) \_\_\_\_\_
- Guardian \_\_\_\_\_ (if family relationship, please list) \_\_\_\_\_

Are there any siblings? (Please list name and age) \_\_\_\_\_

Has your child ever been in group care before? (Please check all that are appropriate.)

- \_\_\_\_\_ Sunday School / Church (on a regular basis)
- \_\_\_\_\_ Other Child Care (where) \_\_\_\_\_ (length of stay)
- \_\_\_\_\_ Mother's Day Out (length of stay) \_\_\_\_\_

Does your child have any medical conditions? (Please check all that are appropriate.)

- |                 |   |           |          |
|-----------------|---|-----------|----------|
| _____ Vision    | Child wears glasses?                        | _____ yes | _____ no |
| _____ Hearing   | Child wears hearing aids?                   | _____ yes | _____ no |
| _____ Speech    | Child currently seen by speech therapist?   | _____ yes | _____ no |
| _____ Motor     | Child currently seen by physical therapist? | _____ yes | _____ no |
| _____ Allergies | Please list: _____                          |           |          |

Are there any family pets? (Please list.) \_\_\_\_\_

Is your child potty trained? \_\_\_\_\_ yes \_\_\_\_\_ no

Child's favorite activity to do alone? \_\_\_\_\_

Child's favorite activity to do with his / her parents? \_\_\_\_\_

Child's favorite food? \_\_\_\_\_

Do you read to your child: \_\_\_\_\_ daily \_\_\_\_\_ weekly \_\_\_\_\_ other

What areas of your child's development are weak and would you like to see worked on in this program?  
(Make any additional comments on the line following the category.)

\_\_\_\_\_ Social (playing with other children, shares, waits turn, sits quietly...)

\_\_\_\_\_ Hygiene / Self Help (manages bathroom facilities, dresses self, cleans up...)

\_\_\_\_\_ Cognitive (counting, alphabet, colors, shapes, classifying...)

\_\_\_\_\_ Language (talks in full sentences, use proper tense / pronoun...)

\_\_\_\_\_ Motor (walking, hopping, throws / catches ball, climb stairs...)

\_\_\_\_\_ Manipulative (buttons, zips, cuts with scissors, copies letters...)

Any additional information you would like to share concerning your child?  
\_\_\_\_\_

Does your child receive any special services during the school year that we need to know about or could assist?  
\_\_\_\_\_

Is there any other information about your child that I have not asked? \_\_\_\_\_

Are there any special celebrations in your family that we should know about? (Kwanza, Hanukka, etc.)  
\_\_\_\_\_  
\_\_\_\_\_