

Dear Parents / Guardians

Please help me help your child through orientation by completing this form.

Child's Name _____

Please list your child's favorite...

Breakfast food _____

Lunch food _____

Snack food _____

Song _____

Books _____

Videos _____

Toy or stuffed animal _____

Cartoon character _____

Game _____

Inside activity _____

Outside activity _____

If my child has trouble falling asleep I usually: _____

My child is afraid of: _____

Other people who have regular contact and are involved with my child's care (grandparents, step parents, siblings, friends, etc.)...

Name _____ Relationship _____

Name _____ Relationship _____

Anything else you would like to share about your child to help him/her feel more comfortable (especially in the first week when we are brand new to each other)...



DROP-IN CHILDCARE FLEXIBLE FULL TIME CARE