

CHILD INFORMATION GUIDE

TO BE FILLED OUT BY THE OUT-OF-HOME CARE PROVIDER AT THE TIME THE CHILD IS READY TO LEAVE YOUR HOME. As your child's caregiver you are often aware of the special things that the child is used to that makes him/her feel "at home". Please take a few minutes and share some of your "secrets" to help your child adjust faster to his/her new home. Just answer the questions that apply to this child and leave the rest blank. This is a four (4) page form, section 1 – 4 is directed to a younger child and sections 2 - 12 to an older child.

_____ has lived with me for _____ Age of child: _____
(Name of child) (Length of time)

1. Eating:

- a. What time are meals served? _____
- b. When are snacks served? _____
- c. What snacks are served? _____
- d. What foods does the child dislike? _____
(or is allergic to?) _____
- e. What are the child's favorite foods? _____

For babies only:

- a. What formula is used? _____
- b. How often does the baby eat? _____
- c. Any solid foods? _____
- d. List any feeding problems.

2. Bathing:

- a. Is there a set time for bathing? _____
- b. Does the child like a bath a shower or both? _____
- c. Any fears of water? _____

3. Bedtime:

- a. What time does the child go to bed and, if applicable, nap? Bed _____ Nap _____
- b. Is there a bedtime ritual (a bath, a story, a prayer)?

- c. What kind of bed does the child sleep in? _____
- d. Who does the child sleep with in his/her room? _____
- e. Is a light left on? Yes No _____
- f. Does the child sleep with anything special (a pacifier, a bottle, etc.)?

- g. Does the child wake up at night? Yes No Why? _____
- h. Does the child wet the bed? Yes No How is bed-wetting handled?

4. When the child needs comfort:

- a. What technique is the child accustomed to (*kisses, hugs, backrub, etc.*)? _____
- b. How is the child held (*arms, shoulder*)? _____
5. When discipline is needed, what works?

6. Comment on some of the special problems you have had with the child:

7. Eating:

- a. What is your family's meal schedule?
- _____
- What is the teen's meal routine?
- _____
- b. Have you observed any symptoms of anorexia, bulimia, or hoarding?
- _____
- c. Any food allergies? _____
- d. What are the teen's food likes and dislikes?
- _____
- e. Does the teen show excessive preference for junk food? Yes No
- _____
- f. Has sugar intake been monitored due to effects on behavior/functioning? Yes No
- _____

8. Personal Hygiene:

- a. Is there a preference for a bath shower? _____
- b. If a girl, does she menstruate? Yes No Any problems?
- _____
- c. If a boy, does he shave? Yes No _____
- d. Indicate the teen's desire or requirements for special hygiene products.
- _____
- e. Does the teen require monitoring of hygiene care? Yes No
- _____

9. Bed:

- a. If there is a regular time for going to bed, indicate time. _____
- b. Has the teen slept in a room alone or with others? _____
- c. Are there any special needs (*lights on, door open/shut, music, reading, etc.*)?

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. **Behaviors:**

- a. Give a brief description of the teen's daily routine.
- b. Any acting out? Describe. Frequency?
- c. Any indications of sexual abuse, and/or inappropriate sexual activity? Yes No If yes, explain.
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- d. Any lying or stealing? Yes No If yes, give example.
- e. Is the teen abusive to others or animals? Yes No If yes, explain.
- f. Does the teen date yet (*single date, group date, keep a curfew*)? Yes No If yes, explain.
- g. How does the teen handle peer relationships?
- h. Does the teen smoke? Yes No _____
- i. Have there been any examples of substance abuse experimentation or problems (*drugs, alcohol*)?
 Yes No If yes, explain.

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. **Hobbies:**

- a. Give a brief description of the teen's interest/ability for hobbies and/or sports.
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- b. Does the teen show interest in school or church activities? Yes No
-

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. **School:**

- a. Any truancy problems? Yes No If yes, explain.
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- b. Indicate special interests.
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- c. Indicate overall attitude toward school (*rules, authority and structured setting*).
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. **Comments:**

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