Polka Dot Preschool

## Child's Sleep Preferences

**(To be added to Parent Enrollment Package)**

Name of Child: _____

Date of Birth: _____

Time child normally goes to bed at night: _____

Time child normally wakes up in the morning: _____

Regular nap times: _____

Please indicate if your child doesn't nap :_____

What is your child's normal routine for falling asleep? For example, do they fall asleep on their own or do you stay with them and rub their back? Let us know what works at home. While we may not be able to do what you do at home, staff will make every effort to support your child in getting a good rest.

Please provide us with any information that will help staff support your child in establishing and maintaining a sleep routine:

Do you want information about how to encourage your child to fall asleep on their own? If so, let us know your questions or concerns so we can best support you in finding resources

I have read the Centre's Sleep Policy : _____ _____

Parent's Signature Date

_____

Supervisor's Signature