DEVELOPMENTAL HISTORY AND BACKGROUND INFORMATION

Regulations for licensed child care facilities require this information to be on file to address the needs of children while in care.

CHILD'S NAME_____ **DATE OF BIRTH**_____

Note: Please provide information for Infants and Toddlers (marked) as appropriate to the age of your child.
Blue Note: If you have filled this form out previously this information is not needed again.

DEVELOPMENTAL HISTORY

Age began sitting _____ crawling _____ walking _____ talking _____
*Does your child pull up? _____ *Crawl? _____ *Walk with support? _____
Any speech difficulties? _____
Special words to describe needs _____
Language spoken at home _____*Any history of colic?_____
*Does you child use pacifier or suck thumb? _____ *When? _____
*Does your child have a fussy time? _____ *When? _____
*How do you handle this time? _____

HEALTH

Any known complication at birth? _____
Serious illnesses and /or hospitalizations:

_____
Special physical conditions, disabilities: _____
Allergies i.e. asthma, hay fever, insect bites, medicine, food reactions:

_____

_____
Regular medications: _____

EATING HABITS

Special characteristics or difficulties:

_____
*If infant is on a special formula, describe its preparation in detail

_____

_____
Favorite foods: _____
Foods refused: _____
*Is your child fed help in lap? _____ High chair? _____
*Does your child eat with spoon? _____ Fork? _____ Hands? _____

TOILET HABITS

*Are disposable or cloth diapers used? _____
*Is there a frequent occurrence of diaper rash? _____
*Do you use oil _____ powder _____ lotion _____ other _____
*Are bowel movements regular? _____ How many per day? _____
*Is there a problem with diarrhea? _____ constipation? _____
*Has toilet training been attempted? _____
*Please describe any particular procedure to be used for your child at the center

_____
What is used at home? pottychair? _____ special child seat? _____ regular seat? _____
How does your child indicate bathroom needs (include special words)? _____
Is your child ever reluctant to use the bathroom? _____
Does the child have accidents? _____

SLEEPING HABITS

*Does your child sleep in a crib? _____ Bed?_____

Does your child become tired or nap during the day (include when and how long)? _____

_____

Please note: The American Academy of Pediatrics has determined that placing a baby on his/her back to sleep reduces the risk of sudden Infant Death Syndrome (SIDS). SIDS is the sudden and unexplained death of a baby under one year of age. If your child does not usually sleep on his/her back, please contact your pediatrician immediately to discuss the best sleeping position for your baby. Please also take the time to discuss you child's sleeping position with your caregiver.

When does your child go to bed at night? _____ and get up in the morning? _____

Describe any special characteristics or needs (stuffed animal, story, mood on walking etc.) _____

_____

SOCIAL RELATIONSHIPS

How would you describe your child: _____

_____

Previous experience with other children/day care: _____

Reaction to strangers: _____ Able to play alone: _____

Favorite toys and activities: _____

Fears (the dark, animals, etc): _____

How do you comfort your child: _____

What is the method of behavior management/discipline at home: _____

_____

What would you like your child to gain from this childcare experience? _____

_____

DAILY SCHEDULE: Please describe your child's schedule on a typical day.

*For infants, please include awakening, eating, time out of crib/bed, napping, toilet habits, fussy time, night bedtime, etc.

_____

_____

_____

Is there anything else we should know about your child?

_____

_____

_____

Parent/Guardian Signature: _____ Date:_____