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DEVELOPMENT & BACKGROUND

DEVELOPMENTAL HISTORY AND BACKGROUND INFORMATION			
Child Name:		**Date of Birth:**	

Regulations for licensed childcare facilities require this information to be on file to address the needs of children while in care. Please provide information for Infants and Toddlers (marked *) as appropriate to the age of your child.

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 your child use pacifier or suck thumb? _____ *When? _____

*Does your child have a fussy time? _____ *When? _____

*How do you handle this time? _____

HEALTH

Any known complications at birth? _____

Serious illnesses and/or hospitalizations: _____

Special physical conditions, disabilities: _____

Allergies i.e. asthma, hay fever, insect bites, medicine, food reactions: _____

_____

_____

Regular medications: _____

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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 held 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? _____

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Does your 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 your 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 waking 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? _____

_____

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

_____

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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 SIGNATURE _____ **DATE** _____

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