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:_____

Allergies:_____

_____

Developmental History

Any known complications at birth:_____

Has your child received any E.I. services:_____

Has your child had any previous group child care experience:_____

Does your child know any other children at our center:_____

How does your child usually react to a new situation:_____

How would you describe your child's personality:_____

What language is spoken in your home:_____

What are your child's favorite activities:_____

What are your child's favorite toys:_____

Does your child have a tension outlet(thumb sucking, head banging, nail biting etc). If yes, please describe:_____

_____

How does your child express his/her feelings:_____

Any speech difficulties:_____

Does your child use any special words to describe needs:_____

Can your child dress him/herself:_____

What are your expectations of our program regarding your child's development:_____

_____

Health

Has your child had any serious illness or hospitalization, if yes, please describe:_____

Does your child have any allergies(asthma, food, hay fever, insect bites, medication etc:_____

Are any medications regularly given:_____

Is your child taking any medications now (including aspirin, laxatives, vitamins etc.):_____

What arrangements have you made for care should your child become ill at the center:_____

Eating

What is your child's general attitude towards eating:_____

Does your child feed him/herself:_____

Toilet/Diapering Habits

Is your child toilet trained:_____If no, has toilet training been attempted:_____

Does your child have any special words used to indicate that they have to use the bathroom:_____

Does your child have accidents:_____

Can your child be relied upon to indicate his/her bathroom wishes:_____

Does your child wet the bed at night/frequency:_____

Sleeping Habits

What time does your child go to bed at night:_____

What time does your child wake in the morning:_____

Does your child sleep in a bed or crib:_____

Does your child sleep with anything (i.e. blanket, toy, pacifiers):_____

Does your child take naps:_____for how long_____

Does your child wear diapers or pull ups to bed:_____

Social Relationships

Has your child had any experiences playing with other children:_____

By nature is your child: Friendly_____ Aggressive_____ Shy_____ Withdrawn:_____ Outgoing_____ Nervous_____

Is your child frightened by anything (i.e. dark, loud noises, animals, storms etc.):_____

How do you comfort your child:_____

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

Please add any additional information that would help us to provide the best environment for your child:

_____ _____

Parent Signature Date