



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:** _____

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: _____

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: _____
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- *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 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)? _____
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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) _____
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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)