# 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.

**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

______________________________________________________________________________

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 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 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: ______________________