



## Developmental History & Background Information

Regulations for licensed child care 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

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

### 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 child use a 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? \_\_\_\_\_

### **Diapering/Toileting 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 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 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. \_\_\_\_\_

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Is there anything else we should know about your child? \_\_\_\_\_

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Parent/Guardian Signature

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Date