The Center for the Development of Children
4 Springdale Ave.
PO Box 279
Dover, MA 02030

Sandy Blinn, Director (508)785-1835

# 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:** _____

Nick Name:_____

Siblings:

Name:_____ Age:_____

Name:_____ Age:_____

Name:_____ Age:_____

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 a pacifier or suck his 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? Potty Chair?_____ 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.***

Describe any special characteristics or needs (stuffed animal, story, mood on waking etc)

_____

When does your child go to bed at night?_____

When does your child get up in the morning?_____

**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)