

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? _____

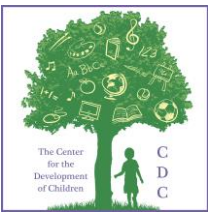
Serious illnesses and/or hospitalizations: _____

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? _____

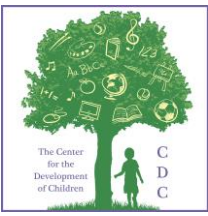
Does your child have accidents? _____

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.



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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)