

# The Center for the Development of Children

4 Springdale Ave.  
Dover, MA 02030

Diana E. Workman, 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: \_\_\_\_\_

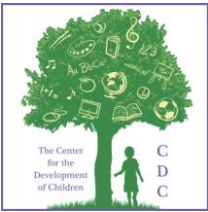
Special physical conditions, disabilities: \_\_\_\_\_

**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? \_\_\_\_\_

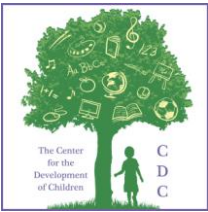
## SLEEPING HABITS

\*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)