Child's Name ______________________ **Date of Birth** __________
Nickname

DEVELOPMENTAL, SOCIAL AND HEALTH HISTORY

We want to provide your child with the best care possible. Please help us get to know your child by filling out this questionnarie. Thank you!

Daily Living Routines

Sleeping

Please describe your child's usual bedtime routine.

Does your child sleep well? ______________ About how long each night? __________

What is your child's usual bedtime? __________

Does your child nap? ______ How many times per day? __________ How long? ____

Does your child sleep with a special blanket or toy? ______________________

Does your child go to bed with a pacifier? ______ Bottle? __________

Does your child have sleep disturbances - nightmares, sleepwalking, waking at night or difficulty

Yes No

If Yes, please describe ______________________

Do you have any concerns about your child's sleep habits?

___

Eating

Would you say your child generally enjoys eating? ______________________

What are some of your child's favorite foods? ______________________

Is your child on any special diet? Describe below. (Please note: State law requires a special form signed by your child's health provider if your child has any diet modifications)

___

Does your child have any allergies? __________ If so, what? ______________________

Are there any foods you do not want us to offer your child?

Are there any foods special to your home or culture that you would like us to offer?

What does your child use to drink? (*Please circle all that apply*) Bottle Tippy Cup Regular cup

If your child uses a bottle, what type of nipple? ______

How does your child eat? Hands ______ Spoon ______ Fork ______

Do you have any concerns or questions about your child's eating?

______

Morning Routine

Does your child eat breakfast before coming to day care?

Yes ☐ No ☐

Can you child dress him/herself? Yes ☐ No ☐

Do you have a morning routine that helps your child prepare for child care?

______

offer some useful suggestions!

Toileting

Does your child use diapers? Yes ______ No ______

If yes, what kind? Disposable ______ Cloth ______

If cloth, what type of cover? Plastic pants ______ Diaper wraps ______

Is your child potty trained? ______

Does your child use a potty or the toilet? ______

Does your child use training pants? ______

How does your child let you know that it's time "to go"? ______

______

Families tend to use a variety of words to describe bathroom activities. What words does your child use

urine ______ bowel movement ______

genital area ______

Do you have any questions or concerns about your child's toilet habits? ______

______

not permitted to launder diapers on the premises.

Physical Health

Your child's regular health care provider:

Name: ______

Address: ______

______

______

Phone: ____________________

Last physical exam: ____________________

Your child's dentist:

Name: ____________________

Address: ____________________

____

____

Phone: ____________________

Last dental exam: ____________________

Would you like assistance finding a health care provider or dentist?

Yes __________ No __________

Immunizations: Please complete the immunization form. State law requires that all children be

Has you child had any health problems in the past? __________ If yes, please describe.

____

____

Does your child have any health problems presently? __________ If yes, please explain.

____

____

Does your child have any chronic health conditions? (For example, asthma, epilepsy, diabetes)

Yes __________ No __________ If yes, please fill out the chronic health form

Does your child have any developmental delays, special needs or learning problems?

If yes, please explain. ____________________

(Would you be interested in meeting with the teachers and directors to help us plan to meet your child's needs?)

Yes __________ No __________

Is your child using any medication at this time? __________ If yes, please explain.

(Please include ointments, drops, over-the-counter medications, and lotions)

____

____

medications must be in their original containers with your child's name printed on the label along with the pharmacy's

Do you have any concerns about your child's health? __________ If yes, please explain.

____

____

Children in group care become ill with colds, viruses, etc. several times per year. At times, we are

Do you have a "back-up" plan in case your child is ever excluded from child care? Please provide

Name: ______________________

Phone: ______________________

Relationship ______________________

Development

Do you have any concerns or questions about your child's hearing? ________

If yes, please explain: ______________________

____

Do you have any concerns or questions about your child's vision? ________

If yes, please explain: ______________________

____

What is your child's primary language? ______________________

What languages are spoken in your home? ______________________

Do you have any questions or concerns about your child's speech and language development? ________

If yes, please explain: ______________________

____

Do you have any concerns or questions about your child's ability to move? ________

Social and Emotional Development

Has your child been in child care before? Yes ________ No ________

If yes, how many different places? (Please list)

____

____

How does your child respond in group situations? ______________________

____

____

Does your child enjoy playing with others? ______________________

____

Does you child enjoy playing alone? ______________________

____

What kinds of activities does your child enjoy? (Games, TV, outdoor play, watching others, puzzles, blocks, books

____

____

How would you describe your child's tempermant and personality? (Examples: quiet, shy, moody, intense,

____

____

What is the best way to comfort your child? ____________________

____

How do you guide/teach your child correct behavior? ____________________

____

Does your child fear certain things? (For example, loug noises, dogs, the dark, clowns)

____

Upsetting events, losses (such as separation, divorce, or death in the family) and change can affect
Yes ____________ No ____________
If yes, please explain: ____________________

____

Who lives at home with your child? ____________________

____

Do you have any questions or concerns about your child's social and emotional development or behavior?
If yes, please explain: ____________________

____

What can we do to help ease your child's adjustment to child care?

____

____

What would you like to see your child gain/learn at our child care center? ____________

____

____

Do you have any questions about our health and safety policies, this questionnaire or anything else?

____

____