Preschool Developmental History

Today's Date _____

Child's Name _____ Nickname _____

Date of Birth _____ Gender: M F

Please list the names and ages of siblings:

_____ _____

_____ _____

Developmental History

Has your child had any previous group care experience? Yes No

Does your child know any other children at the center? Yes No

How does your child usually react to new situations? _____

How would you describe your child's personality? _____

What language is spoken in your home? _____

What are your child's favorite activities? _____

What are your child's favorite toys? _____

Does your child have any special fears (animals, storms, loud noises, etc.)? Yes No

If yes, please describe: _____

Does your child have a tensional outlet? (thumb sucking, head banging, nail biting, hair pulling)? Yes No

If yes, please describe: _____

How does your child express his/her feelings? _____

At what age did your child begin talking? _____

Does your child have any speech problems? _____

Can your child dress her/himself? Yes No

Do you have some particular expectations of our program regarding your child's development?

Health

Has your child had any serious illness or hospitalization? _____

If yes, please describe: _____

Does your child have any allergies (asthma, hay fever, insect bites, medicines, or food)? _____

If yes, please describe: _____

Are any medications given regularly? _____

Does your child seem well most of them time? Yes No

Is your child taking any medications now (including aspirin, laxatives, vitamins, etc.)? Yes No

If yes, what/why? _____

What arrangements have you made for care should your child become ill at the center? _____

_____

Preschool Developmental History

Eating

What is your child's general attitude toward eating? _____

Does your child have any food allergies? Yes No

If yes, please describe: _____

Does your child feed her/himself? Yes No

Toilet / Diapering Habits

Is your child toilet trained? Yes No

If yes, does your child have accidents? Yes No

Can our child be relied upon to indicate her/his bathroom wished? Yes No

Does your child wet the bed at night? Yes No How frequently? _____

Sleeping Habits

What time does your child go to bed at night? _____

Does your child sleep with a blanket? Yes No

Does your child sleep with a toy? Yes No

Does your child take naps? Yes No

Does your child wear diapers at bedtime? Yes No at naptime? Yes No

Does your child have any problems with nightmares? Yes No

Social Relationships

Has your child had any experiences playing with other children? _____

By nature is your child: Friendly? _____ Aggressive? _____ Shy? _____ Withdrawn? _____

How does your child relate to strangers? _____ Does your child play well alone? _____

Is your child frightened by: Animals? _____ Rough children? _____ Loud noises? _____ Dark? _____

Storms? _____ Anything else? _____

How do you comfort your child? _____

Please add any additional information that would help us to provide the best environment for your child:

_____ _____

Parent/Guardian's Signature Date