Toddlers Developmental/Health History

Child's Full Name:	Nickname:
Date of Birth:	Gender: ❒ Male ❒ Female
Address:	Phone Number:

Family Information

Father:	Mother:
Address (if different than child's):	Address (if different than child's):
Occupation:	Occupation:
Employer:	Employer:
Work Phone:	Work Phone:
Marital Status:	Marital Status:
Church: Member: Yes No	Church: Member: Yes No
Pastor:	Pastor:

Other children in the family (names and ages)? _____

_____

If child is adopted: age of adoption? _____ Does child know?_____

If there's been a separation or divorce: who does the child live with? _____

_____

If living with someone other than parents: Name_____ Relationship_____

Address:_____ Phone:_____

Health History

Type of birth: Normal or Premature Birth Weight: _____

Crawling? Yes No Walking? Yes No At what month or age? _____

Talking? Yes No Does child speak in words or sentences?

_____

Difficulty speaking? _____Difficulty hearing? _____

Can they be understood by adults? _____ Speak different languages? _____

Does your child seem well most of the time? ❒ Yes ❒ No

Is your child taking any medications now? ❒ Yes ❒ No

If yes, please list and explain for what purpose:

In a year, has your child had 3 or more ear infections? ❒ Yes ❒ No

In a year, does your child usually have more than 3 colds or sore throat infections with a fever?

❒ Yes ❒ No

What arrangements have you made for the care of your child should he/she become ill while in child care?

Does your child have any health-related needs or physical disabilities that you would like us to be aware of?

❒ Yes ❒ No If yes, please list:

Does your child have any contagious illnesses that could impact other children or staff? ❒ Yes ❒ No

If yes, please provide details:

Has your child ever been hospitalized? ❒ Yes ❒ No

If yes, please provide details:

Has your child had any serious accidents or poisonings? ❒ Yes ❒ No

If yes, please provide details:

Does your child chew unusual things such as pencils, chalk, cribs, window ledges, paint chips, plaster, or hair? ❒ Yes ❒ No

If yes, please provide details:

Is your child allergic to anything? ❒ □Yes ❒ □No

If yes, please list, and note the symptoms your child usually exhibits when having an allergic reaction:

Developmental History

How do you comfort your child?

What are your child's favorite toys?

What are your child's favorite activities?

What language(s) is/are spoken in your home?
Has your child been in a group care setting before? If yes, what was his/her experience there?
Have there been any major life changing events that could affect your child? (Divorce, death of a loved one, moving, etc?)
What goal(s) do you have for your child at PROMOTE Family Preschool and Childcare?
What is your child's current sleeping schedule? Nighttime: Morning nap: Afternoon nap: Other (list):
Does your child use a pacifier at naptime? ❒ Yes ❒ No
Does your child use a special toy at naptime? ❒ Yes ❒ No If yes, please list:
Does your child use a blanket at naptime? ❒ Yes ❒ No

Feeding

What is your child's current eating schedule? (please specify times and how much the child usually eats) Nighttime: Morning: Afternoon: Snacktime:
Please list any special food likes/dislikes or feeding concerns we should be aware of:

Toileting

Is your child toilet training? ❒ Yes ❒ No If yes, how much assistance does he/she need in the bathroom? (For example, with dressing/undressing, hand washing, getting on/off the potty, etc.)
How frequently does your child have a bowel movement?
Does your child often get a diaper rash? ❒ Yes ❒ No If yes, how do you treat it?
Please list any other toileting concerns you feel we should be aware of: