Developmental and Background Information

Child's Name: _____	Date of Birth: _____
Any Speech Difficulties:	
Special Words to describe Needs:	
Language spoken at home:	
Health	
Any complication at Birth? ☐ NO ☐Yes- Describe	
Serious Illnesses and or hospitalizations/When	
Special Physical conditions or disabilities	
Allergies- i.e. asthma, hay fever, insect bites, medicine, food reactions	
Regular Medications: Side Effects:	
Eating Habits	
Favorite Foods	Foods Refuse
Toilet Habits	
Does your child use diapers/pull-ups ☐ Yes ☐ No	
Does your child have accidents: ☐ Yes ☐ No	
Is your child reluctant to use the bathroom ☐ Yes ☐ No	
Any special words your child uses to indicate bathroom needs	
Sleeping Habits	
Does your child become tired or nap during day (include when and how long)	
When does child go to bed at night	Up in the morning
Describe any special needs to help rest	
Social Relationships	
Describe your child	
Previous experience with other children/child care	
Fears your child has	
Reaction to strangers	Able to play alone
Favorite toy/activity	

Child's Name: _____

Developmental and Background Information

How do you comfort your child

What is the method of behavior management / discipline at home?

What do you want your child's experience to be at our school?

Name three goals you have for your child this year

Daily Schedule

Describe your child's typical daily schedule for us

Is there any else we should know about your child?

Members in your family

Please list all the members in your family:

Parent /Guardian Signature; _____ Date: _____