

CHILD/FAMILY PERSONAL HISTORY

The purpose in securing information about your child is to help the child care staff better understand your child and to help you know what to expect from the child care center. Your child's care during the day is a responsibility we share. All information is kept confidential and requires your written permission if it is to be shared. Please use the back sides of this form if you wish to elaborate more on a question. Some questions may not be applicable to your child at this time, please leave them blank.

FAMILY AND SOCIAL HISTORY

CHILD'S NAME _____ BIRTH DATE _____

MARITAL STATUS OF PARENTS

MARRIED _____ DIVORCED _____ SEPARATED _____ SINGLE PARENT _____

CUSTODY/VISITING ARRANGEMENTS _____

SIBLINGS

NAME _____ AGE _____

NAME _____ AGE _____

NAME _____ AGE _____

OTHER MEMBERS OF HOUSEHOLD _____

PERSONAL HISTORY

TYPE OF BIRTH: _____ FULL TERM _____ PREMATURE

ANY COMPLICATIONS? _____

AGE HE/SHE BEGAN SITTING _____ CRAWLING _____ WALKING _____

IS HE/SHE A GOOD CLIMBER? _____ DOES HE/SHE FALL EASILY? _____

AGE CHILD BEGAN TALKING _____ SPEAK IN WORDS OR SENTENCES? _____

DOES CHILD HAVE ANY SPEECH PROBLEMS? _____ DESCRIBE _____

OTHER LANGUAGE _____

SPECIAL WORDS TO DESCRIBE CHILD'S NEEDS _____

EATING PATTERNS

IS CHILD USUALLY HUNGRY AT MEAL TIME? _____ BETWEEN MEALS? _____

WHAT ARE HIS/HER FAVORITE FOODS? _____

WHAT FOODS ARE REFUSED? _____

ANY EATING PROBLEMS? _____

ANY FOOD ALLERGIES? _____

DOES CHILD EAT WITH A SPOON? _____ FORK? _____ HANDS? _____

IS CHILD LEFT OR RIGHT HANDED? _____

OTHER DIETARY RESTRICTIONS? _____

TOILET PATTERNS

CAN YOUR CHILD BE RELIED UPON TO INDICATE TOILETING WISHES? _____

WHAT WORD IS USED FOR URINATIONS? _____ BOWEL MOVEMENT _____

DOES THE CHILD NEED TO GO MORE FREQUENTLY THAN USUAL FOR AGE? _____

IS HE/SHE FRIGHTENED OF THE BATHROOM? _____

DOES HE/SHE HAVE ACCIDENTS? _____ HOW DOES HE/SHE REACT? _____

DOES THE CHILD NEED HELP WITH TOILETING? _____

DOES THE CHILD WET HIS/HER BED AT NIGHT? _____ HOW OFTEN? _____

HEALTH HISTORY OF CHILD

WHAT PAST ILLNESS HAS CHILD HAD:

____ CHICKEN POX ____ SCARLET FEVER ____ DIABETES ____ MEASELS ____ MUMPS

____ HIV ____ AIDS ____ HEPATITIS A ____ HEPATITIS b ____ OTHER (_____)

DOES YOUR CHILD HAVE FREQUENT COLDS? ____ EAR ACHES? ____
SORE THROAT ____ STOMACH ACHES? ____

DOES HE/SHE FOMIT EASILY? ____ RUN HIGH FEVERS EASILY? ____

HAS YOUR CHILD HAD ANY SERIOUS ACCIDENTS? ____ EXPLAIN _____

ALLERGIES? ____ HOW DOES IT MANIFEST ITSELF? ____ ASTHMA ____ HAY FEVER
____ HIVES ____ OTHER (____) ALLERGY CAUSED BY _____

HAS YOUR CHILD EVER BEEN:
HOSPITALIZED? _____ EXPLAIN _____

HAS YOUR CHILD EVER BEEN TO A DENTIST? _____

DOES YOUR CHILD HAVE ANY DISABILITIES? _____ EXPLAIN _____

PLEASE GIVE A STATEMENT OF YOUR EVALUATION OF YOUR CHILD'S OVERALL HEALTH.

GENERAL INFORMATION

DOES YOUR CHILD HAVE ANY OTHER PROBLEMS WE SHOULD BE AWARE OF?

BRIEFLY DESCRIBE YOUR CHILD (physical appearance, personality, abilities, etc.)

WHAT ARE YOUR EXPECTATIONS FOR YOUR CHILD AT THE CENTER?
