

The Learning Tree Child Care Center

Infant Developmental History



Information

Today's Date _____
 Child's Name _____ Birth Date _____

Schedule

Please circle the days your child will be in child care
 Monday Tuesday Wednesday Thursday Friday
 Hours that your child will be in child care: _____

Developmental History

Allergies _____
 Special health conditions (attach additional page if necessary) _____

 Comforting Needs: _____
 Communication: _____
 How do you comfort your child? _____

 What are your child's favorite toys? _____

 What are your child's favorite activities? _____

 What language(s) is spoken in your home? _____

Sleeping

Do you have any specific ways of helping your child go to sleep?

 Does your child sleep on his back, stomach or side? _____
 Does your child cry when going to sleep? Yes No
 What is your child's current sleeping schedule?
 Night Time: From _____ To _____
 AM nap: From _____ To _____
 PM nap: From _____ To _____
 Does your child use a pacifier at naptime? Yes No
 Does your child use a special toy at naptime? Yes No
 Does your child use a blanket at naptime? Yes No

Toileting

How frequently does your child have a bowel movement _____
 Appearance of bowel movement _____
 Does your child have diaper rash often Yes No
 If yes, how is the rash treated _____

Continued on following page...

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Infant Developmental History Continued



Feeding

Is your baby breast-fed? Yes No Bottle Fed Yes No
 Type of bottle _____ Nipple _____
 Formula _____
 Does your baby need to be burped? _____
 If so, how often? _____

What is your child's present eating schedule (please specify amounts)

Time	Juices	Food	Milk/Formula
Breakfast			
Lunch			
Snack			

Does your child have any feeding problems? _____
 If yes, please explain _____

Additional information if needed: