

The Learning Tree Child Care Center

Preschool Developmental History



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

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: _____				

Health	Please indicate which communicable disease/s your child has had		
	Measles (Big Red)	Measles (3 Day)	
	Mumps	Chicken Pox	
	Whooping Cough	Other	_____
	Has your child had any serious illnesses or accident/s?	Yes	No
	If yes, please explain	_____	
	Has your child ever been hospitalized?	Yes	No
	If yes, please explain why	_____	
	Does your child have any physical disabilities?	Yes	No
	If yes, please describe	_____	
	Are there any foods your child cannot eat?	Yes	No
	If yes, please provide names of foods	_____	
What arrangements can you make for your child's care during times of illness?			
Does your child have any breathing concerns? _____			
Does your child have any allergies? _____			

Personal History	Is your child a good climber?	Yes	No
	Does your child fall easily?	Yes	No
	At what age did your child begin talking?	_____	
	Does your child speak in words or sentences?	_____	
	Does your child have any special words to describe his/her needs?	Yes	No
	If so, please share them with us	_____	
	What language(s) is spoken in your home?	_____	

Bathroom Habits	Can your child be relied upon to indicate his/her bathroom needs?	Yes	No
	Does your child have frequent toilet accidents?	Yes	No
	Can your child meet his/her toileting needs independently?	Yes	No

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Preschool Developmental History Continued



Sleeping Habits What is your child's current sleeping schedule?

Night Time: From _____ To _____
 PM nap: From _____ To _____

Does your child like having their back rubbed to fall asleep?

What is your child's mood upon waking? _____

Social Relationships

Has your child had experience playing with other children? Yes No

If no, please explain _____

Do you feel your child will adjust easily to a child care environment? Yes No

If no, please explain _____

Does your child enjoy being alone? Yes No

If no, please explain _____

Is your child frightened by any of the following (please circle all that apply)

Animals The Dark Loud Noises Storms Other: _____

By nature, is your child (please circle all that apply)

Friendly Aggressive Shy Withdrawn

How does your child react to strangers? _____

What makes your child angry? _____

How does your child show his/her feelings? _____

What do you find is the best way of handling your child when he/she is upset? _____

Who does most of the disciplining in your family? _____

How do you comfort your child? _____

In what particular way can we help your child this year? _____

What do you hope to gain for yourself and/or your child from our program? _____

Family Background

Mother's name _____

Father's name _____

With which parent does your child reside Both Mother Father

Does your child spend time with both parents? _____

If you are seperated, _____

how often does your child see the non-custodial parent? _____

Please list other members of the household by name and relationship _____

Does your child have any pets? What are their names? _____

