

The Learning Tree Child Care Center

Toddler 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	Does your child seem to be feeling well most of the time?	Yes	No	
	In one year, does your child have as many as 3 ear infections?	Yes	No	
	Are you concerned about your child's hearing?	Yes	No	
	In one year, does your child have as many as 3 colds or sore throat/infections with a fever?	Yes	No	
	Are you concerned about your child's eyes or vision?	Yes	No	
	Has your child been seen by a medical specialist?	Yes	No	
	If yes, please give Dr's name and reason seen	_____		

	What arrangements have you made for your child if he/she becomes ill while at The Learning Tree?	_____		
	Does your child have any special needs?	Yes	No	
	If yes, please describe those needs	_____		
	Does your child have any other illnesses or diseases?	Yes	No	
	If yes, please state what they are	_____		
	Has your child ever been hospitalized?	Yes	No	
	If yes, please explain why	_____		
Has your child had any serious accidents or poisonings?	Yes	No		
If yes, please explain why	_____			

Has your child had any of the following (please circle)				
Premature birth	Head Injury	Eczema	Food intolerance	
Birth injury or defect	Trouble breathing at birth	Hives	Hay fever	
Convulsions/seizures	Allergies	Asthma	Colic	
Wheezing	Insect Stings			
If any of the above were circled, please describe				

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Toddler Developmental History Continued



Developmental History

At what age did your child begin to walk? _____

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? _____

Has your child been in a group child care setting previously? Yes No

Does your child have any specific fears? Yes No

If yes, how do you handle them? _____

Sleeping

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

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 special toy at naptime Yes No

Does your child use a pacifier 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? _____

Is your child toilet trained? Yes No

What word does your child use for urination? _____

What word does your child use for bowel movement? _____

Does he/she use a potty chair at home? Yes No

Can he/she easily manage the clothing worn? Yes No

Any additional information you feel would help us meet your child's needs: