



# Easton Learning Adventures Preschool

115 Main Street, North Easton, MA 02356  
(508) 230-7445

## Developmental History and Background Information

CHILD'S NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

\*Note: Please provide information for Infants and Toddlers (marked \*) as appropriate to the age of your child.

### DEVELOPMENTAL HISTORY

Age began sitting \_\_\_\_\_ crawling \_\_\_\_\_ walking \_\_\_\_\_ talking \_\_\_\_\_

\*Does your child pull up? \_\_\_\_\_ \*Crawl? \_\_\_\_\_ \*Walk with support? \_\_\_\_\_

Any speech difficulties? \_\_\_\_\_

Special words to describe needs \_\_\_\_\_

Language spoken at home \_\_\_\_\_ \*Any history of colic? \_\_\_\_\_

\*Does your child use pacifier or suck thumb? \_\_\_\_\_ \*When? \_\_\_\_\_

\*Does your child have a fussy time? \_\_\_\_\_ \*When? \_\_\_\_\_

\*How do you handle this time? \_\_\_\_\_

### HEALTH

Any known complications at birth? \_\_\_\_\_

Serious illnesses and/or hospitalizations: \_\_\_\_\_

Special physical conditions, disabilities: \_\_\_\_\_

**Allergies i.e. asthma, hay fever, insect bites, medicine, food reactions:**

Regular medications: \_\_\_\_\_

### EATING HABITS

Special characteristics or difficulties: \_\_\_\_\_

Favorite foods: \_\_\_\_\_

Foods refused: \_\_\_\_\_

\* Is your child fed held in lap? High chair? \_\_\_\_\_

\* Does your child eat with spoon? Fork? Hands? \_\_\_\_\_

### TOILET HABITS

\*Are disposable or cloth diapers used? \_\_\_\_\_

\*Is there a frequent occurrence of diaper rash? \_\_\_\_\_

\*Do you use: oil powder lotion other \_\_\_\_\_

\*Are bowel movements regular? \_\_\_\_\_ how many per day? \_\_\_\_\_

\*Is there a problem with diarrhea? \_\_\_\_\_ constipation? \_\_\_\_\_

\*Has toilet training been attempted? \_\_\_\_\_

\*Please describe any particular procedure to be used for your child at the center  
\_\_\_\_\_

What is used at home? pottychair? \_\_\_\_\_ special child seat? \_\_\_\_\_ regular seat? \_\_\_\_\_

How does your child indicate bathroom needs (include special words): \_\_\_\_\_

Is your child ever reluctant to use the bathroom? \_\_\_\_\_

Does the child have accidents? \_\_\_\_\_

### **SLEEPING HABITS**

\*Does your child sleep in a crib? \_\_\_\_\_ Bed? \_\_\_\_\_

Does your child become tired or nap during the day (include when and how long)? \_\_\_\_\_  
\_\_\_\_\_

When does your child go to bed at night? \_\_\_\_\_ and get up in the morning? \_\_\_\_\_

Describe any special characteristics or needs (stuffed animal, story, mood on walking etc) \_\_\_\_\_

### **SOCIAL RELATIONSHIPS**

How would you describe your child: \_\_\_\_\_  
\_\_\_\_\_

Previous experiences with other children: \_\_\_\_\_

Reaction to Strangers: \_\_\_\_\_ Able to play alone: \_\_\_\_\_

Favorite toys and activities: \_\_\_\_\_

Fears (the dark, animals, etc.): \_\_\_\_\_

How do you comfort your child: \_\_\_\_\_

What is the method of behavior management/discipline at home: \_\_\_\_\_  
\_\_\_\_\_

What would you like your child to gain from this child care experience?  
\_\_\_\_\_  
\_\_\_\_\_

### **DAILY SCHEDULE**

Please describe your child's schedule on a typical day.  
\_\_\_\_\_  
\_\_\_\_\_

Is there anything else we should know about your child?  
\_\_\_\_\_  
\_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_