

# Child History



*Your child's care is a shared responsibility. To meet your child's needs, the TPCDC teachers would like to have a better understanding of your child's developmental history and family culture. All information is confidential and made available only to your child's primary caregivers. Please help us by completing this form in detail and use the last page to elaborate more on any question.*

## Family Information

Name of Child \_\_\_\_\_ Date of Birth \_\_\_\_\_

Date Completed \_\_\_\_\_ Current Age of Child \_\_\_\_\_

Ethnicity/Race of the child (please select one or more below):

- Hispanic/Latino of any race,
- American Indian or Alaska Native,
- Asian,
- Black or African American,
- Native Hawaiian or Other Pacific Islander,
- White, or
- Two or more races.

Parent Guardian #1 \_\_\_\_\_

Email: \_\_\_\_\_

Parent Guardian #2 \_\_\_\_\_

Email: \_\_\_\_\_

Custody/Visitation Arrangements \_\_\_\_\_

(all legally enforced custodial orders must be submitted with the child's records)

Sibling Names and Ages \_\_\_\_\_

Other Household Members & Relationship to Child \_\_\_\_\_

What languages are spoken at home? \_\_\_\_\_

Are there special words we should use to communicate with your child? \_\_\_\_\_

## Developmental & Health History

How would you rate your child's overall health? \_\_\_\_\_

Does your child have a chronic illness or a medical condition which would impact their participation in our program?  No  Yes, describe \_\_\_\_\_

(If yes, child must have a completed Care Plan)

Does your child have an IEP/IFSP or receive early intervention services?  No  Yes \_\_\_\_\_

(Please provide a copy to the Center)

Does your child have a physical disability or limitation?  No  Yes \_\_\_\_\_

Does your child run high fevers easily?  No  Yes \_\_\_\_\_

Does your child have allergies? No Yes \_\_\_\_\_  
(If yes, child must have a completed medical care plan)

Does your child have asthma? No Yes \_\_\_\_\_  
(If yes, child must have a completed Asthma care plan)

Do you have concerns about your child's speech? No Yes \_\_\_\_\_

Do you have other concerns about your child's physical growth or development? No Yes \_\_\_\_\_

Do any of these special needs require special care by our teachers? \_\_\_\_\_ If so, please describe: \_\_\_\_\_

What programs or individuals work with your child in regards to their special needs? \_\_\_\_\_

(If yes, please sign a Release of Information so they can inform us about how to provide enhanced support to your child)

### Sleep Habits

Does your child nap? No Yes, for \_\_\_\_\_ hours.

The child normally sleeps at night from \_\_\_\_\_:\_\_\_\_\_ p.m. to \_\_\_\_\_:\_\_\_\_\_ a.m.

Upon awakening, the child's mood generally is: \_\_\_\_\_

Does your child have their own room? No Yes.

A special item to sleep with? \_\_\_\_\_

### Eating Habits

What are your child's favorite foods? \_\_\_\_\_

What foods does your child dislike or refuse? \_\_\_\_\_

How would you rate your child's appetite? Healthy Picky Varies \_\_\_\_\_

Does your child eat with their hands or utensils?

Does your child have eating difficulties? No Yes \_\_\_\_\_

Does your child have any dietary restrictions? No Yes \_\_\_\_\_

(If yes, child must have a completed food substitution form)

### Toilet Habits

Is your child fully potty trained? No Yes (if No, complete below)

What word does your child use for urination? \_\_\_\_\_ Bowel Movement? \_\_\_\_\_

Can your child indicate toileting needs? No Yes Needs assistance

Does your child have frequent toileting accidents? No Yes Wet the bed during sleep? No Yes

Fear the toilet? No Yes

The child wears diapers pull-ups or training pants under-wear

### Social Relationships

Describe your child's relationship to others \_\_\_\_\_

Describe some activities your child enjoys at home \_\_\_\_\_

Would you describe your child as friendly shy aggressive withdrawn other \_\_\_\_\_

What makes your child happy? \_\_\_\_\_

What would make your child upset or angry? \_\_\_\_\_

How does your child show their feelings? \_\_\_\_\_

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

What age group does your child prefer to play with? \_\_\_\_\_

Does your child prefer to play by themselves in a small group or a large group?

Does your child know other children at the Center? No Yes \_\_\_\_\_

How do you feel your child will adjust to the program? \_\_\_\_\_

Does your child have difficulty with separation? No Yes \_\_\_\_\_

Does your child relate well to other adults? No Yes \_\_\_\_\_

How did your child interact with other children and adults? \_\_\_\_\_

What do you think will happen the first day you leave your child with us? \_\_\_\_\_

Describe any fears your child may have \_\_\_\_\_

Personal History

Briefly describe your child's personality, abilities and interests \_\_\_\_\_

Tell us about your child's favorite toys, games \_\_\_\_\_

What discipline approach is used at home? \_\_\_\_\_

What expectations or goals do you have for your child at the center, or list aspects of ways we can support your child and family? \_\_\_\_\_

In Social Relationships? \_\_\_\_\_

In Emotional Development? \_\_\_\_\_

In Physical Development? \_\_\_\_\_

In Cognitive and Intellectual Growth? \_\_\_\_\_

In Other Ways? \_\_\_\_\_

Does your child have a different sleeping/mealtime/ activity schedule in another setting (babysitter, relative/neighbor care/school)? \_\_\_\_\_

Your Child In Care

Has your child been in an early learning or child care program before? \_\_\_\_\_ If yes, would you share some information with us (What type of Care? Where? When? For How Long?) \_\_\_\_\_

