Toddler Developmental/Health History

Child's Full Name	Nickname
Date of Birth Gender	Gender: ❒ Male ❒ Female

Health History

Does your child seem well most of the time? ❒ Yes ❒ No

Is your child taking any medications now? ❒ Yes ❒ No

If yes, please list and explain for what purpose:

In a year, has your child had 3 or more ear infections? ❒ Yes ❒ No

In a year, does your child usually have more than 3 colds or sore throat infections with a fever?

❒ Yes ❒ No

What arrangements have you made for the care of your child should he/she become ill while in child care?

Does your child have any health-related or other needs that you would like us to be aware of?

❒ Yes ❒ No

If yes, please list:

Does your child have any contagious illnesses that could impact other children or staff? ❒ Yes ❒ No

If yes, please provide details:

Has your child ever been hospitalized? ❒ Yes ❒ No

If yes, please provide details:

Has your child had any serious accidents or poisonings? ❒ Yes ❒ No

If yes, please provide details:

Does your child chew unusual things such as pencils, chalk, cribs, window ledges, paint chips, plaster, or hair? ❒ Yes ❒ No

If yes, please provide details:

Is your child allergic to anything? ❒ Yes ❒ No

If yes, please list, and note the symptoms your child usually exhibits when having an allergic reaction:

Developmental History

At what age did your child begin to walk? To talk?

How do you comfort your child?

What are your child's favorite toys?

What are your child's favorite activities?

What language(s) is/are spoken in your home?

Has your child been in a group care setting before? If yes, what was his/her experience there?

Sleeping

Please list any specific ways you help your child go to sleep

What is your child's current sleeping schedule?
Nighttime:
Morning nap:
Afternoon nap:
Other (list):

Does your child use a pacifier at naptime? ❒ Yes ❒ No

Does your child use a special toy at naptime? ❒ Yes ❒ No

If yes, please list:

Does your child use a blanket at naptime? ❒ Yes ❒ No

Feeding

What is your child's current eating schedule? (please specify times and how much the child usually eats)

Nighttime:

Morning:

Afternoon:

Snacktime:

Please list any special food likes/dislikes or feeding concerns we should be aware of:

Toileting

Is your child toilet trained? ❒ Yes ❒ No

If yes, how much assistance does he/she need in the bathroom? (for example, with dressing/undressing, hand washing, getting on/off the potty, etc.)

How frequently does your child have a bowel movement?

Does your child often get a diaper rash? ❒ Yes ❒ No

If yes, how do you treat it?

Please list any other toileting concerns you feel we should be aware of: