Developmental Information

Date: _____

The purpose of this form is to help the primary teacher gain a better understanding of your child. Please feel free to add any information which you think might be helpful. Do not feel obligated to complete questions of which you are unsure or do not apply. We are always available if you feel the need to discuss anything with us.

<table>
<tr><td>Child's Name</td><td>Nickname</td><td>Height</td><td>Weight</td><td>Birth Date</td><td>Birthplace</td></tr>
<tr><td colspan="3">With whom does the child live? (Check one or both)
☐ Mother
☐ Father
Name and Age of:
Brothers _____
_____
_____
Sisters _____
_____
_____</td><td colspan="3">Is your child toilet trained? ☐ Yes ☐ No
☐ In process
What does your child say when wishing to use the toilet?
Does your child need help in:
☐ Dressing ☐ Undressing ☐ Toileting
Does your child have a room alone? ☐ Yes ☐ No
If no, who shares room?
Does your child take a nap ☐ Yes ☐ No</td></tr>
<tr><td colspan="3">Brothers and sisters not living with child:
Name & Age: _____
Name & Age: _____</td><td colspan="3">Does your child have any special fears?
Does your child have any special problems?</td></tr>
<tr><td colspan="3">Other people your child sees frequently</td><td colspan="3">Has your child ever been tested for a learning disability of developmental delay? ☐ Yes ☐ No</td></tr>
<tr><td colspan="3">Does your child visit grandparents frequently?
☐ Yes ☐ No ☐ Deceased</td><td colspan="3">Does your child have any allergies? ☐ Yes ☐ No
If yes, to what?</td></tr>
<tr><td colspan="3">By what names or nicknames are the grandparents called?</td><td colspan="3">Does your child require medication on a continuous basis?
☐ Yes ☐ No
Which medication?</td></tr>
<tr><td colspan="3">Has your child been cared for by anyone other than a parent?
If child attended a child care center, please name:</td><td colspan="3">Does your child have any history of:
Vision impairment or eye infection? ☐ Yes ☐ No
Hearing impairment or ear infection? ☐ Yes ☐ No
Speech problems? ☐ Yes ☐ No</td></tr>
</table>

General Information:

Do you have any concerns about how your child will adjust to our program? _____

_____

Is there anything special we should know about your child or your family? (e.g. recent move, change in family size, etc.) _____

_____

What do you hope to gain from your association with Poway Country Preschool? _____

_____

What do you hope your child will gain from his / her experiences with us? _____

_____

Sleeping:

What is your child's current daily sleeping schedule?

Morning wake-up _____ Evening Bedtime _____ Daily naps _____

Is your child sleeping through the night? ☐ Yes ☐ No If not, when does your child usually wake up at night?

_____

Are there any special ways to help your child sleep? _____

What position does your child lie in to sleep? _____

(NOTE: To prevent SIDS, the American Academy of Pediatrics recommends that infants not be placed on their stomachs to sleep)

Social / Emotional:

What upsets or frightens your child? _____

What does your child find soothing or comfortable? _____

How is your child now reacting to strangers? _____

_____

Does your child . . . ☐ Use a pacifier ☐ Suck thumb

Feeding:

Is your child using a ☐ cup ☐ bottle ☐ both

Are you breast feeding your child? ☐ Yes ☐ No If yes, at what times? _____

Will you be providing us with expressed milk? ☐ Yes ☐ No

What are the times your child is now receiving a bottle each day? _____

_____

Give the number of ounces your child is now taking at each bottle feeding _____

Is your child taking ☐ formula ☐ whole milk ☐ other _____

Are there any other special instructions concerning bottle feeing your child? _____

_____

Is your child now on baby food or table food? _____

List foods your child is now eating:

Vegetables: _____

Fruits: _____

Meats: _____

Juices: _____

Is your child now eating finger foods? ☐ Yes ☐ No If yes, please list _____

_____

List any other foods your child is now eating. _____

_____

How is your child fed? ☐ held in lap ☐ high chair ☐ high chair ☐ with assistance ☐ independently

Eating Schedule:

Time	Food Amount	Drink Amount	Instructions
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Does your child have a history of colic? ☐ Yes ☐ No

Cognitive Development:

Where does your child like to spend his / her waking hours? (Crib, playpen, crawling on floor, etc.) _____

_____

_____

What toys and activities make him / her happy? _____

_____

Has your child begun to talk? ☐ Yes ☐ No What words? _____

_____

Physical Development:

Is there anything about your child's physical development that we should know? _____

_____

_____

_____

Elimination / Diapering:

When does your child usually have bowel movements? _____

_____

Has your child begun potty training? ☐ Yes ☐ No If yes, describe his / her routine. _____

_____

_____

What does your child call his / her bowel movement? _____ Urination? _____

Does your child have diaper rash frequently? ☐ Yes ☐ No

Which of the following diapering products do you use? ☐ Oil ☐ Powder ☐ Lotion ☐ Other _____

_____

What type of diaper do your currently use?

☐ Disposable ☐ Cloth ☐ Pull-up Size: _____

Does your child wear plastic pants? ☐ Always ☐ Sometimes ☐ Never

Other Information for Teacher:

_____

_____

_____

_____

_____

_____

_____

_____ _____

Signature of Parent / Guardian Date