

THE COMMONWEALTH OF MASSACHUSETTS  
Department of Early Education and Care

**DEVELOPMENTAL HISTORY AND BACKGROUND INFORMATION**

Regulations for licensed child care facilities require this information to be on file to address the needs of children while in care.

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

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: \_\_\_\_\_

\*If infant is on a special formula, describe its preparation in detail: \_\_\_\_\_

\_\_\_\_\_

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 your 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)? \_\_\_\_\_  
\_\_\_\_\_

***Please note: The American Academy of Pediatrics has determined that placing a baby on his/her back to sleep reduces the risk of Sudden Infant Death Syndrome (SIDS). SIDS is the sudden and unexplained death of a baby under one year of age. If your child does not usually sleep on his/her back, please contact your pediatrician immediately to discuss the best sleeping position for your baby. Please also take the time to discuss your child's sleeping position with your caregiver.***

- 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 waking etc) \_\_\_\_\_  
\_\_\_\_\_

**SOCIAL RELATIONSHIPS**

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

Previous experience with other children/day care: \_\_\_\_\_  
\_\_\_\_\_

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 childcare experience? \_\_\_\_\_  
\_\_\_\_\_

**DAILY SCHEDULE**

Please describe your child's schedule on a typical day. For infants, please include awakening, eating, time out of crib/bed, napping, toilet habits, fussy time, night bedtime, etc. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

\_\_\_\_\_  
(Parent/Guardian Signature)

\_\_\_\_\_  
(Date)