

Child/Family Personal History

1 of 4

The purpose in securing this information about your child is to help the child care staff better understand your child and to help you know what to expect from the child care center. Your child's care during the day is a responsibility we share. All information is kept confidential and requires your written permission if it is to be shared. Please use the back sides of form if you wish to elaborate more on a question. Some questions may not be applicable to your child at this time; please leave them blank.

Family and Social History

Telephone _____

Name of Child _____ Birth Date _____

Mother (or guardian) _____ Age _____

Father (or guardian) _____ Age _____

Marital Status of Parents:

Married _____ Divorced _____ Separated _____ Single Parent _____
(How Long?) (How Long?)

Remarks _____

Custody/visiting arrangements _____

Siblings

Name _____ Birth Date _____

Name _____ Birth Date _____

Name _____ Birth Date _____

Other members of the household (include relationship and age):

How long have you lived in this city? _____

Do you speak a language at home other than English? _____

Are there any special words that would help us communicate with your child? _____

Are there any cultural practices or holidays you would like us to know about? _____

Continued

Personal History

Type of Birth: ___ Full Term ___ Premature

Any complications? _____

Age he/she began sitting _____ Crawling _____ Walking _____

Is he/she a good climber? _____ Does he/she fall easily? _____

Age he/she began talking _____ Does he/she speak in words _____ or sentences? _____

Does he/she have any speech problems? _____

Other language _____

Special words to describe his/her needs _____

Sleeping

What time does child go to bed? _____ Awaken? _____

Is he/she ready for sleep? _____ Does he/she have his own room? _____

Own bed? _____ Does he/she walk, talk or cry out at night? _____

What does he/she take to bed with him? _____

What is his/her mood on awakening? _____

Does he/she take naps? (From when to when?) _____

Social Relationships

Has he/she had experiences in playing with other children? _____

By nature, is he/she ___ friendly? ___ aggressive? ___ shy? ___ or withdrawn?

How does he get along with his brothers and sisters? _____

Other adults? _____

With what age child does he/she prefer to play? _____

Will he/she know any children in the center? _____

Do you feel he/she will adjust easily to the child care situation? _____

What makes him/her angry or upset? _____

How does your child show his/her feelings? _____

What method of behavior control is used in your home? _____

What is child's usual reaction? _____

Continued

Child/Family Personal History

3 of 4

Who does most of the disciplining? _____

Is he/she frightened by any of the following: _____ animals? _____ tall people? _____ rough children?
_____ loud noises? _____ dark? _____ storms? _____ Anything else? _____

Favorite toys and activities at home _____

Does he/she like to be read to? _____ listen to music? _____

Does he/she prefer to play outdoors? _____ Can your child ride a tricycle? _____

Has he/she had experience with: _____ clay _____ scissors _____ easel painting
_____ finger painting? _____ blocks? _____ water play? _____

Does your child have any other problems that we should be aware of? _____

Health History of Child

What past illnesses has he/she had? At what age?

_____ Chicken Pox _____ Scarlet Fever _____ Diabetes _____ Malaria
_____ HIV _____ AIDS _____ Measles _____ Hepatitis A _____ Hepatitis B
_____ Mumps _____ Other _____

Does your child have frequent colds? _____

Explain _____

_____ Tonsillitis? _____ Ear Aches _____ Stomach Aches _____

Does he/she vomit easily? _____ Does he/she run high fevers easily? _____

Has your child had any serious accidents? _____ Explain _____

Is child allergic? _____ If so, how does it usually manifest itself? _____ Asthma _____ Hay fever _____

Hives _____ Other _____ Do you know what his/her allergy is caused by? _____

Has your child ever been hospitalized? _____ What for? _____

Has your child ever been to a dentist? _____ Has he had his vision tested? _____

Hearing tested? _____ Does he wear corrective shoes? _____

Does your child have any handicaps? _____ Describe _____

Please give a statement of your evaluation of your child's overall health. _____

Continued

Eating

Is child usually hungry at mealtime? _____ between meals? _____

What are his/ her favorite foods? _____

What foods are refused? _____

What eating problems does the child have? _____

Any food allergies? _____

Does child eat with a spoon? _____ fork? _____ hands? _____

Is child left or right handed? _____ What time does your child usually eat breakfast? _____

lunch? _____ dinner? _____ Is family vegetarian? _____

Other dietary restrictions _____

Toilet Habits

Can the child be relied upon to indicate his toileting wishes? _____

What word is used for urination? _____ For bowel movement? _____

Does the child need to go more frequently than usual for his age? _____

Is he/she frightened of the bathroom? _____ Does he/she have accidents? _____

How does he/she react to them? _____

Does child need help with toileting? _____ Was the child easy or difficult to toilet train? _____

Does the child wet his/her bed at night? _____ How often? _____

Briefly describe your child (physical appearance, personality, abilities, etc.)

What are your expectations for your child at the center? In what particular ways can we help your child?
