

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: \_\_\_\_\_
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- \*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)? \_\_\_\_\_
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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: \_\_\_\_\_
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- 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)