Precious Lambs, Inc.
Early Childhood & Child Care Center

CHILD HEALTH & DEVELOPMENTAL HISTORY

The information will help us better provide for your child. All information will be kept confidential.

Child's Name _____ Date_____

BIRTH INFORMATION

Were there any problems with pregnancy? _____ No _____ Yes with birth? ____ No ____ Yes

Any problems before or after birth? ____No _____Yes

DEVELOPMENTAL MILESTONES

At what age did your child begin Crawling____ Walking_____ Talking_____

Can/does your child Dress self ____ Undress self _____ Feed Self_____

HEALTH INFORMATION

Please indicate any illnesses/problems your child currently has or has had in the past.

__Allergies	__Skin/Eczema	__Vision/Glasses
__Speech	__Asthma/Breathing	__Heart condition
__Surgery	__Seizures	__Hearing/Earing infections
__Bone/Muscle concerns	__Bowel/Bladder accidents	__Urinary Tract Infections
__Other- Diabetes	__Blood conditions-anemia, hemophilia	

Please explain any items checked above_____
_____
_____.

Does your child take medication regularly? ___No ___Yes

If so, please explain?_____

Is your child presently or ever been diagnosed with a special need? ____No ____Yes

630 Broadway Avenue, Holbrook, NY 11741
Tele: 631-319-1667 Fax: 631-319-1669
www.preciouslambschildcare.com

If so, is your child receiving any special services? Please explain_____

_____

TOILETING HABITS

How does your child indicate bathroom needs (include special words)? _____

Is your child reluctant to use the bathroom? __No __Yes If yes, how do you handle

_____

Does your child have accidents? __No __ Yes If yes, how often & when? _____

EATING HABITS

At what time does the child eat: Breakfast ____ Lunch___ Dinner_____

Does your child eat a snack between meals? _____No _____Yes

Does your child feed him/herself? ___No __ Yes Use a fork____ spoon_____

Does your child drink out of a cup? ____No ____Yes

What is your child's general attitude toward eating?_____

_____

If he refuses to eat, how is that handled and by whom?_____

_____

Favorite foods _____ Disliked foods_____

Is your child allergic to any food items? ___No _____Yes EPIPEN_____

Please list foods allergic to _____

Symptoms _____

SLEEP HABITS

At what time does your child wake up in the morning ?_____ go to sleep at night?_____

Does your child nap on a regular basis? ___ No ____ Yes Time _____ # hours

Can your child fall asleep by themselves? _____No _____ Yes

What do you do to encourage your child to sleep? _____

_____

SOCIAL RELATIONSHIPS

How would you describe your child?

_____

_____

What are your child's abilities and interests?

_____

_____

Has there been any previous child care experience? ___No ___ Yes

What are some ways in which your child plays at home ? Favorite toys? Activity?

_____

_____

Does your child play by themselves ? _____No ___ Yes with others? ____No ___ Yes

How does your child interact with other children?_____

_____

Does your child have any fears (the dark, animals)?

_____

_____

How do you comfort your child?

_____

_____

How do you discipline your child?

_____

_____

Is there anything you would like us to know about your child ?

_____

_____