
Date Form Completed

Developmental/Family Information for Toddlers

Child's Name _____ DOB _____ Age _____ Gender _____

By what name would you like your child to be called? _____

Home Address _____ Phone _____

Are both parents living? _____ yes _____ no

Are the parents _____ married _____ divorced _____ separated _____ never married?

Who is the legal guardian? _____

If the parents are not living together what are the custody/visiting arrangements? _____

2nd Home Address (if applicable) _____ Phone _____

Primary Parent/Guardian's Name _____

Relationship to the child _____

Employer Name and Address _____

Occupation _____ Work Phone _____

E-mail _____ Cell Phone _____

Parent/Guardian's Name _____

Relationship to the child _____

Employer Name and Address _____

Occupation _____ Work Phone _____

E-mail _____ Cell Phone _____

Besides the child, who else lives in the household?

<u>Name</u>	<u>Age</u>	<u>Relationship to the child</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are there any unusual circumstances in the family situation which you believe might influence your child's behavior? If yes please explain _____

What languages does your child understand and speak? _____

What languages do the parents speak in the home? _____

Health Information

Current pediatrician's name _____ Phone Number _____
Address _____ City _____ State _____ Zip Code _____

Medication

Is the child on medicine for a long-term condition (illness, allergy, etc.)? _____

If yes, please complete a Student Health History & Emergency Care Plan.

What is the medication's name and purpose? _____

If the child does not receive the medication, what reactions or changes in behavior might be seen? _____

Procedure to follow if this reaction is seen. _____

Has the child had serious injuries? _____ If yes, please explain _____

How old was the child when it occurred? ____ Has your child ever been hospitalized? ____

<u>Diagnosis</u>	<u>Age</u>	<u>Length of stay</u>	<u>Hospital</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Check if your child has or has had any of these illnesses:

- Allergy Asthma Bronchitis Chicken Pox Convulsions
- Croup Diarrhea Fainting Hepatitis Hernia
- Frequent Vomiting Food Sensitive Measles
- Rickets Nosebleeds Muscle Weakness Heart Defect
- Meningitis Mumps Tonsillitis Headaches Hives
- Pneumonia Underweight Overweight Kidney Infection
- Eczema skin rash Sever stomach ache

Other _____

Has the child seen a(n):

Ophthalmologist/Optometrlist?	Y/N	_____ age	_____ result
Audiologist?	Y/N	_____ age	_____ result
Speech Therapist?	Y/N	_____ age	_____ result
Psychologist/Counselor	Y/N	_____ age	_____ result
Dentist?	Y/N	_____ age	_____ result

Current Dentist Name _____ **Phone Number** _____

Social/Emotional/Developmental History

Is your child adopted? _____ If so at what age? _____ Place of birth _____

What are your child's favorite activities? _____

What are your child's favorite toys? _____

Is your child used to playing with other children? _____ If yes, what ages are those children, and in what settings? _____

At what age did your child begin to sit? _____ crawl? _____ walk? _____

Which, if any, of the following are concerns of the parent(s)? Circle all that apply.

<i>Excessive crying</i>	<i>inactive</i>	<i>biting</i>
<i>Aggressiveness</i>	<i>temper tantrums</i>	<i>change in routine</i>
<i>Stranger anxiety</i>	<i>quietness</i>	<i>shyness</i>
<i>Over-independence</i>	<i>thumb-sucking</i>	
<i>Other?</i> _____		

Describe any fears your child may have. _____

Describe how your child deals with anxieties and conflicts. _____

Your Child's Routine

Please describe your child's feeding schedule

	Time	Food/Drink	Amount
Morning	_____	_____	_____
Afternoon	_____	_____	_____
Evening	_____	_____	_____
Other times	_____	_____	_____

What are your child's favorite foods? _____

What foods are refused? _____

What family practices do you have about how much your child is to eat? _____

What family practices do you have about when and what kinds of snacks are available? _____

Does your child have any particular eating problems? _____

Please describe your child's nap/sleep schedule and routine.

Time of Day/Night	Length	Body Position(younger)	Self-Soothing Behavior
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Who generally puts your child to bed? _____

Does your child take a pacifier? _____ yes _____ no If yes, when? _____

What do you do to help your child go back to sleep? _____

When do you plan to start potty training? _____

What do you expect your child to gain from this school experience? _____

Is there any information not specifically asked on this form that you feel the child's teacher should know about? If so please explain. _____

Religious Affiliation

Are you a member of Our Lady of the Presentation Parish? _____ yes _____ no

If Catholic what parish do you belong too? _____

Is your family non-catholic? _____ yes _____ no

Vehicle Identification

Vehicles will be used by the following people:

Car #1

Make _____ Model _____ Year _____ Color _____ License Plate # _____

Car #2

Make _____ Model _____ Year _____ Color _____ License Plate # _____

Thank you for your cooperation in completing this form.

Parent/Guardian Signature

Date