# YMCA ECLC Toddler Developmental History

Child's Name:_____ Birth date: _____
Gender: ____
Parent/Guardian: _____

## Health:

Does your child seem well most of the time?
❑ Yes ❑ No (Please explain): _____
_____
_____

Does your child have an Individualized Education Plan (IEP) or IFSP?
❑ No ❑ Yes (Please explain): _____
_____
_____
_____

Is your child currently taking any medications?
❑ No ❑ Yes (Please explain) _____

Does your child have any allergies?
❑ No ❑ Yes (Please explain) _____
_____

In a year, has your child had 3 or more ear infections? ❑ Yes ❑ No

Are you concerned about your child's hearing? ❑ Yes ❑ No

Are you concerned about your child's eyes or vision? ❑ Yes ❑ No

In a year, does your child have more than 3 colds, sore throats, or infections with a fever?
❑ No ❑ Yes (Please explain): _____
_____
_____

Has your child ever been hospitalized?
❑ No ❑ Yes (Please explain): _____
_____
_____

Has a medical specialist seen your child?
❑ No ❑ Yes (Please explain): _____
_____
_____

What arrangements have you made for the care of your child should s/he become ill at the center? _____
_____
_____

Does your child chew on unusual things such as pencils, chalk, window ledges, paint chips, plaster, or hair?
❑ No ❑ Yes (Please explain): _____
_____

Has you child had any of the following? (Circle all that apply)
**Premature birth / Trouble breathing at birth / Birth injury or defect / Head injuries / Convulsion or seizures**
(Please explain): _____
_____
_____

Describe your child's sleep habits:
Number of nighttime hours: _____
Napping hours (time of day about # of hours): _____
_____

Items your child sleeps with: _____
_____

Items your child sleeps with: _____
_____

Ways you help your child go to sleep: _____
_____
_____

Does you child prefer to sleep on his/her stomach? ❑ Yes ❑ No

Optional: Does your child have any contagious illnesses that could impact other children or staff
**(Malaria, Hepatitis A, Hepatitis B, HIV/AIDS)**? If yes, please explain: _____
_____
_____
_____

## Emotional Background:

What previous group experience has your child had and what was his/her reaction? _ _____
_____
_____
_____
_____
_____

Does anyone take care of your child on a regular basis? _____
_____
_____

How does your child react to babysitters and new people/situations? _____
_____
_____
_____

How do you comfort your child? _ _____
_____
_____

What are your child's favorite toys? _ _____
_____
_____

What are your child's favorite activities? _____

_____

## Feeding:

What is your child's present eating schedule? Provide specific amounts

| | Juice | Food | Milk/Formula |
|---|---|---|---|
| Breakfast | | | |
| Lunch | | | |
| Snack | | | |
| Dinner | | | |
| Other | | | |

Does your child have any feeding problems?
❑ No ❑ Yes (Please explain): _____

_____

_____

## Toileting:

Is your child potty training at home or fully potty trained?
❑ No ❑ Yes (Since when): _____

How frequently does your child have bowel movements? _____
Appearance of bowel movements: _____

_____

Does your child have diaper rash often? ❑ Yes ❑ No
How is it treated? _____

_____

_____

## Social Background:

What is your child's primary language? _____

Other languages spoken: _____

Does your child have siblings?
❑ No ❑ Yes # of brothers _____ # of sisters _____

Does your child have playmates?
❑ No ❑ Yes # of playmates _____ ages of playmates: _____

How does your child get along with other children? _____

_____

How much time does your child spend alone each day? _____

_____

_____

How much time does your child spend outdoors each day? _____
_____
_____

In what situations will your child need the most help? _____
_____
_____

## Special Interests:

What is your child's favorite toy? _____
_____
_____

What play materials holds his/her attention the longest? _____
_____
_____

Is your child interested in books?
❑ No ❑ Yes (Please explain): _____
_____
_____

How does your child react to pets/animals? _____
_____
_____

Are there any cultural specific holidays or celebrations you would like to share? _____
_____
_____

Are there any holidays or celebrations you do not participate in? _____
_____
_____

Are there any routines, spiritual/religious practices that we should be aware of? _____
_____
_____

Are there any other cultural aspects that you want incorporated into your child's learning day? _____
_____
_____

Other comments that will help your child have a positive experience at our center: _____
_____
_____
_____
_____

Parent/Guardian signature: _____ Date: _____
Staff signature _____ Date: _____