Fort Hill
Center for Early Childhood Education
Smith College
28 Lyman Road
Northampton, MA 01063
413-585-3290

DEVELOPMENTAL HISTORY AND BACKGROUND INFORMATION

CHILD'S NAME_____ DATE OF BIRTH_____

*Note: 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 a pacifier or suck thumb?_____When?_____
*Does you 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, e.g., asthma, hay fever, insect bites, medicine, food reactions:
_____
(Please fill out Emergency Health Care Plan, available in Fort Hill Office).
Regular medications:_____
(Please fill out Medication Dispensing Form, available in Fort Hill Office).

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 a lap?_____high chair?_____
*Does your child eat with a spoon?_____fork?_____hands?_____

TOILET HABITS

*Are disposable or cloth diapers used?_____pullups?_____
*Is there a frequent occurrence of diaper rash?___(Please fill out Topical Ointment Form)
*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 Fort Hill:_____
_____
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)?_____
_____

Please note: The American Academy of Pediatrics has determined that placing a baby on his/her back to sleep reduces the risk of Sudden Infant Death Syndrome (SIDS). SIDS is the sudden and unexplained death of a baby under one year of age. If your child does not usually sleep on his/her back, please contact your pediatrician to discuss the best sleeping position for your baby. Please also take the time to discuss your child's sleeping position with your caregiver.

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 upon waking etc.)_____

SOCIAL RELATIONSHIPS
How would you describe your child:_____
_____
Previous experience with other children/group care:_____
_____
_____
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 experience at Fort Hill?_____
_____

DAILY SCHEDULE
Please describe your child's schedule on a typical day.
*For infants, please include awakening, eating, time out of bed/crib, napping, toilet habits, fussy time, night bedtime, etc.

_____
_____
_____

Is there anything else we should know about your child? (Please feel free to add additional information on another sheet on any of the above categories).
_____
_____

Parents'Signatures_____Date_____
(Both where applicable)
_____Date_____