Kiddy Karousel Nursery and Day Care Center
Developmental History
6 Weeks – 35 months

Child's Name _____ Birth Date _____

1. Does your child seem well most of the time? Yes No

2. Does your child take any medications regularly? Yes No
(Include vitamins, aspirin, laxatives)
If yes, what & why:

3. Did your child have at least three ear infections in the last year? Yes No

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

5. In a year, does your child usually have more than 3 colds or sore throat infections with fever? Yes No

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

7. Has your child ever been to see a specialist? Yes No
If yes, who & why:

8. What arrangements have you made if your child becomes ill at the center?

9. Does your child have any handicaps? Yes No
If yes, describe:

10. Other illnesses or diseases? Yes No
If yes, describe:

11. Has your child been hospitalized? Yes No
    If yes, when & for what?

12. Has your child had any serious accidents or poisonings? Yes No
    If yes, what:

13. Has your child had any of the following? (Please circle)
    Premature Birth Birth Injury Head Injury Seizures Convulsions
    Allergies (Eczema, Hives, Drug, Wheezing, Food Intolerance, Asthma, Insect Bites)
    Describe:

14. How do you comfort your child?

15. What are your child's favorite toys?

16. What are your child's favorite activities?

17. Do you have any specific ways of helping your child go to sleep?

18. Does your child cry when going to sleep?

19. What is your child's present sleeping schedule?
    Night From _____ to _____
    AM Nap From _____ to _____
    PM Nap From _____ to _____

20. When at home, does your child sleep on his/her: Back Stomach Side

21. Does your child need a pacifier? Yes No

22. Does your child need a special blanket? Yes No

23. How is your child fed? Breast Bottle Baby food Table food

24. What type of formula does your baby receive?

25. Does your baby need to be burped? Yes No

26. What is your child's present feeding schedule? Please specify amount.
    Breakfast

    Lunch

    Snack

27. Does your child have feeding problems? Yes No
    If yes, what are they?

28. How frequently does your child have a bowel movement?

29. What is the appearance of your child's bowel movement?

30. Does your child have frequent diaper rash? Yes No
    How is it treated?

Please note anything else you would like us to know about your child.