AMAZING LIFE GAMES

A COOPERATIVE PRE-SCHOOL IN WASHINGTON DC

Developmental Health History

Child's Name: ____Birthdate:_____________________

Parent/Guardian (1) email: ____

Phone numbers: ____

Parent/Guardian (2) email: ____

Phone numbers: ____

Safety Contact Information: If an emergency happens at ALG and parent(s)/guardian(s) are not reachable, please list contact information for a local emergency contact below:

Emergency Contact Name: ____

Relationship to Child: ____

Phone Number(s): ____

Email: ____

Nanny/Au Pair/Babysitter Name: ____

Phone Number: ____

Developmental History:

1. At what age did your child first talk? Does he/she have any challenges with talking or making sounds?

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2. At what age did your child first walk? Does he/she have any challenges walking, running or moving?

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3. Compared to other children his/her age, does your child have any visual/sight challenges?

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4. Compared to other children his/her age, does your child have any hearing challenges?

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5. Compared to other children his/her age, does your child have any difficulty using his/her hands for small movements (such as puzzles, drawing, building with legos)?

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Physical Health: Please describe the overall physical health of your child.

1. Are there any significant illnesses or surgeries we should know about?

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2. Are there any food or environmental allergies we should know about? If yes, what is his/her course of treatment (epi-pen, shots, seasonal OTC drugs, etc)?

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3. Is your child on any regular medicine? If yes, what and how frequently?

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4. Does your child have any recurring chronic health illnesses or problems (such as asthma or frequent ear infections)? If yes, please describe.

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5. Does your child have any special needs or diagnosed disabilities we should know about to make accommodations? If yes, please describe.

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6. Are there any other things you would like us to know about your child’s health?

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Daily Living:

1. What is your child's typical eating pattern? ____

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2. Is your child potty trained? ______________ If yes, what age did they get trained? ________________

If no, where is your child in the toilet training process? ______________________________________

____

What word does your child use to express a need to urinate? __________________________________

To have a bowel movement? ____

3. What are your child's sleeping patterns?

Awakes at: ___________ Naps from: ___________ to: ___________Goes to sleep at: ___________

How many nights per week does your child sleep through the night? ____________________________

4. Does your child engage in "screen time"? (tv, computer, smart phone, tablet, videos, games, etc) If so, about how often and for about how long?

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Social Relations/Play:

1. Does your child tend to play more often alone or with peers or siblings? __________________________

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2. Are there areas of play where your child might need extra support (e.g. fear of animals, loud noises, the dark, storms, rambunctious children, etc)? ____

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3. How is your child best comforted when you are not around (e.g. a lovey, rubbing back, a hug, a song, etc)?

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Family Life:

Parent/Guardian (1) Occupation/Place of employment: ____

Parent/Guardian (2) Occupation/Place of employment: ____

1. Parent hobbies, interests that might enrich our program: ____________________________________

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2. Who lives with your child in your home? (please include the names and ages of any siblings)

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3. Do parent(s)/guardian(s) travel on a regular basis? If so, please list a typical travel schedule for the upcoming year: ____

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4. Please describe any significant events happening during your family's life in the next year (e.g. birth of a child, move, change in job, change in childcare, etc). ____

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Parent Signature: ____Date: ________________