FSA Child Care

HEALTH, DIET, DEVELOPMENTAL HISTORY (TODDLER)

Child's name ______________________ Date ____________________

What are your child's abilities? What are your child's interests? What does your child like to do or play with?

____

We would like to include your child's home life and culture in the classroom. What would you like us to know about your family's culture and favorite activities? ________________________________

____

BIRTH INFORMATION

Place of birth ____________ Birth date ____________ Birth wieght ____________

Was oxygen required for the baby? __Yes ___No ___Don't Know
Did the baby cry immediately when born? __Yes ___No ___Don't Know
Did the baby stay longer than the mother in the hospital? __Yes ___No ___Don't Know
Did the baby have difficulty with sucking or crying when first brought to the mother? __Yes ___No ___Don't Know

HEALTH HISTORY

Date of last well child exam ____________ Doctor ____________
Please check the illnesses or problems your child currently has or has had in the past:

________ Allergies ________ Anemia/sickle cell ________ Asthma
________ Constipation ________ Diarrhea ________ Ear problems/infections/hearing
________ Eczema ________ Exposure to tuberculosis (TB) ________ Serious accidents/injuries
________ Heart Trouble ________ Seizures ________ Other:
________ Colic ________ Surgery or hospitalization

Please explain any items checked: ________________________________

Does your child take any medication (vitamins, prescription, or over the counter) on a regular basis? ____________

If yes, what? ________________________________

LEAD EXPOSURE RISK

Check any of the items that pertain to your child/family. These are possible lead exposure risks.

________ Parent concerned child was exposed to lead

________ Child has lived in a home built before 1960

________ Family used utensils made of clay and/or teas made in Mexico

________ Child lives near a factory/mine releasing lead

________ Family member works around lead products

CHILD DEVELOPMENT INFORMATION

Sleeping

Does your toddler sleep on his/her ____Back ____Side

How do you put your child to sleep? ____________________

Do you think your child will sleep at school? ____Yes ____No

Comforters and stressors

How do you know what your child wants? ____________________

My child is comforted by ____________________

My child gets upset when- ____________________

Toilet training

Does your child use the toilet? ____Yes ____No How often? ____________________

how do you know when your child needs to use the toilet? ____________________

Is resistent to ____________________

Responds well to ____________________

FOOD AND NUTRITION INFORMATION

Foods my child likes: ____________________

Foods my child doesn't like: ____________________

Special concerns or allergies: ____________________