Montessori Escuela

Developmental History & Background Information

Student Information

Students Full Name: ____ Date of Birth: ____________
Last *First* *M.I.*

Address: ____

Developmental History

Please provide information for your child as appropriate to the age. Some questions may not apply to children above infant and toddler age. Since many of the following questions may not apply to preschool aged children and children enrolled in Montessori Escuela, you may write N/A where necessary.

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: _________________________ History of Colic?_________________________

Does your child use a pacifier of suck his/her thumb?_______________ When? ______________________

Does your child have a fussy time of day? _______________________ When? ______________________

How do you handle this time? ________________________________

Health

Please provide information for your child as appropriate to the age. Some questions may not apply.

Any known complications at birth? ____

Serious illnesses or hospitalizations?____

Special physical conditions or disabilities? ____

Allergies: asthma, hay fever, insect bites, medicine, food reactions:_____________________________

____

Medications taken regularly: ____

Eating Habits

Please provide information for your child as appropriate to the age. Some questions may not apply.

Special characteristics or difficulties? ___________________________

Favorite Foods?___________________________

Foods refused? ___________________________

Is your child fed in a high chair?__________ Booster seat? __________ At the table? __________

Does your child eat with a spoon?__________ A fork? __________ Hands?__________

Does your child drink from a bottle? __________ A sippy cup? __________ A regular cup?__________

Toilet Habits

Please provide information for your child as appropriate to the age. Some questions may not apply.

Is your child toilet/potty trained? ___________________________

If not, are disposable or cloth diapers used?___________________________

Is there frequent occurance of diaper rash? ___________________________

Do you use baby powder?__________ Baby Oil? __________ Lotion? __________

Are bowel movements regular?__________ How many per day?__________

Is there a problem with Diarrhea? __________ Constipation? __________ A regular cup?__________

If your child is toilet trained, what is used at home? Potty chair?_______ special child seat?_______ regular seat?_______

How does your child indicate bathroom needs? (include special words or signs)___________________________

Is your child ever reluctant to use the bathroom? ___________________________

Does the child have accidents? ___________________________

Please describe any particular procedure to be used for your child in the program: ___________________________

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Sleeping Habits

Please provide information for your child as appropriate to the age. Some questions may not apply.

Does your child sleep in a crib? __________ A bed?__________

Does your child become tired and nap during the day?___________________________

If so, how long? __________ At what time? __________

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 physician immediately to discuss the best sleeping position for your baby. Please also take the time to discuss your child's sleeping position with your educator. Your educator would place your infant on his/her back unless there is a written physician's order that specifies otherwise.

What time does your child go to bed at night? ______________________________

What time does your child awake in the morning? ______________________________

Please describe any special characteristics or needs? (stuffed animal, lovey, toy, object of comfort)______________

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Social Relationships

Please provide information for your child as appropriate to the age. Some questions may not apply.

How would you describe your child? ______________________________

____

What is your child's previous experience with other children or child care?______________________________

____

What is your child's reaction to strangers?______________________________

Does your child play independently?______________________________

Favorite Toys, Animals, etc.? ______________________________

Does your child have any fears? (dark, animals, etc.) ______________________________

How do you comfort your child?______________________________

What is the method of behavior management and discipline at home? ______________________________

____

What would you like your child to gain from this experience? ______________________________

Daily Schedule

Please describe your child's schedule on a typical day (Please include nighttime awakenings, time awake in morning, meal Times, napping, toilet habits, fussy times, bedtime at night, etc):

____

____

Is there anything else we should know about your child?____

____

Parent Name & Signature

Print Name: ____ Date: ______________

Last *First*

Signature: ____