

Preschool/Kindergarten/School-Age Personal Care Plan DEVELOPMENTAL HISTORY FORM

Today's Date: Date of Enrollment/Transition:

Child's Name: Date of Birth: Age:

Date of Last Physical (for WA State only):

What would you like us to call your child?

What languages are spoken at home?

Parent/Guardian Name:

Parent/Guardian Name:

Name of Person Completing Form:

Primary Teacher:

Classroom:

FAMILY INFORMATION

In the columns below list the names of family members residing with the child. Please include siblings, extended relatives, and pets. For each person listed provide the name the child uses to address that individual and include ages of siblings.

| Name | How child addresses this individual? | Age |
|------|--------------------------------------|-----|
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Please list words used in your language corresponding to the English below. Include additional words in the blank columns if needed.

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|---|--|
| I'll take good care of you | |
| I see that you are crying | |
| Time to go outside | |
| I like your smile | |
| Time for snack/lunch | |
| Everyone is resting now | |
| Mommy will be back | |
| Daddy will be back | |
| Time to use the bathroom | |
| Now we wash our hands | |
| It's group time | |
| It's choice time. You can choose what you want to do. | |

If parental custody is shared, describe the custody arrangements:

Please tell us about cultural family customs, rituals, or traditions that will help us make your child's experience more meaningful, including languages spoken at home:

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Child's Name:

DEVELOPMENTAL HISTORY

What languages does your child speak?

Do you have developmental concerns about your child?

Does your child have any speech difficulties? Yes No If yes, explain:

How does your child communicate his/her needs?

CHILD'S HEALTH

List medications regularly taken and conditions requiring them:

Describe serious illnesses or hospitalizations:

Describe special physical conditions, disabilities, allergies, or concerns:

Does your child have a special need?

Explain special services and accommodations, which are different from those provided by the center's routine program (i.e. exercises, equipment, materials, or special services personnel):

Note: For documented medical allergies an Allergy Health Care Plan completed by the child's medical provider is required.

Child's Name:

NUTRITION PRACTICES AND ROUTINES

Does your child have any eating difficulties? Yes No If yes, explain:

.....
.....
.....

List special dietary requests, and restrictions:

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.....
.....

Food likes and eating preferences:

.....
.....
.....

Child eats with: Spoon Fork Fingers Other

Additional Information:

.....
.....
.....

SLEEPING ROUTINES

Does your child become tired or nap during the day? Yes No If yes, what time and for how long?

.....
Pre-nap routines/rituals:

.....

What time does your child go to bed at night? Wake in morning?

At home child sleeps in (Check all that apply): Bed With parents

Child's typical waking behavior/routine/mood:

.....
.....
.....

Special sleeping concerns:

.....
.....
.....

Child's Name:

TOILETING ROUTINES

Is your child reluctant to use the bathroom? Yes No If yes, how do you handle this?

Is your child toilet trained? Yes No Urination Bowels Both If no, does child wear diapers? Yes No

Does your child have accidents? Yes No If yes, how often/when?

What is used at home for toileting? Potty chair Special seat Regular seat Explain:

How can we support toilet learning?

Words used for urination:

Words used for bowel movement:

Are bowel movements regular? Yes No How often/when?

Is there a problem with: Diarrhea Constipation Explain:

COMFORTING CHILD

Describe how adults can comfort your child?

Security object (if any): Name child uses for object/when needed:

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SOCIAL RELATIONSHIPS

Has your child had any experience with group care? Yes No If yes, please describe:

Describe your child's temperament: Determined Outgoing Shy Relaxed Assertive Explain:

How does your child react to new situations and new children and adults?

Does your child prefer to play: Alone In small groups Explain:

Has your child had previous child care experience? Yes No If yes, explain how it met, or did not meet, your expectations?

Child's favorite toys and activities:

Does your child have any fears? Yes No If yes, please explain:

ADDITIONAL PERTINENT INFORMATION

To help us care for your child as an individual, please explain your parenting philosophy:

Is there additional information you feel is important for the staff to know about your child or family?

What do you as a family, hope to get out of this child care experience?

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Child's Name:

Sections of this Personal Care Plan will be updated annually or sooner if requested by a parent/guardian.

Parent/Guardian Signature:Date:

Staff Signature:Date:

| | | | | | |
|-----------------|--|------------------|--|-----------------|--|
| Date of Change: | | Parent Initials: | | Staff Initials: | |
| Date of Change: | | Parent Initials: | | Staff Initials: | |
| Date of Change: | | Parent Initials: | | Staff Initials: | |
| Date of Change: | | Parent Initials: | | Staff Initials: | |

