Caterpillar Learning Child Care
Health/Developmental History

Child Name: _____ DOB: _____

Child Infant History: Birth Weight: ____lbs. ___oz. Any birth complications (circle): YES NO
If yes, describe: _____

Child Illness History: Has your child ever had or does he/she have (check appropriate box):

	Yes	No		Yes	No		Yes	No
Bleeding Disorder			Whooping Cough			Measles (Rubella)		
Cancer			Seizures in the past year			Mumps		
Rheumatic Fever			Frequent Ear Infections			Chicken Pox		
Scarlet Fever			Diabetes			Asthma in the past year		
Nose Bleeds			Sore Throat			Heart/Vascular Disease		

If answered yes, please indicate illness and age at time of illness: _____

_____

_____

Other serious illness/hospitalization: _____

Is your child allergic to anything? Y N If yes than what? _____

What kind of allergic reaction occurs: ð rash ð hives ð vomiting ð wheezing
ð shortness of breath ð other? _____

Compared with his/her siblings and children the same age, has the child been fast, average, slow in (check appropriate box)	Fast	Average	Slow	Comments
Walking, running, climbing				
Talking				
Playing with toys, coloring, drawing				
Understanding what is said to him/her				
Getting along with other children his/her own age				
Sitting up without help				
Crawling				
Learning to use the toilet				
Feeding him/her self				
Dressing him/her self				

Does your child have a diagnosed disability? (Circle) YES NO
If yes, what is the diagnosis? _____

Is your child receiving services for this disability such as therapy or early childhood special education? (Circle) YES NO

Does your child receive any services from the school district? (Circle) YES NO

If answered yes to either of the previous two questions please give the name of the agency or school district providing services and the contact person.

School Name:_____ Contact name: _____

_____ _____
Parent Signature Date

_____ _____
Staff Signature Date