MONTESSORI Escuela

Montessori Escuela, LLC

Developmental History & Background Information

Student Information

Student·s Full Name: DOB:

Address:

Developmental History

Please answer as appropriate for your child·s age; write N/A if not applicable.

Age began sitting: Crawling: Walking: Talking:

How does your child communicate needs?

Any speech, language, or hearing concerns?

Words, gestures, or signs used to express needs:

Languages spoken or understood at home:

Pacifier, thumb-sucking, or comfort item?

Any times or situations your child finds difficult?

What helps your child feel calm and supported?

Health

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

Any birth or early health concerns relevant to current care?

Serious illnesses or hospitalizations?

Health or developmental support needs?

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? __

Where does your child usually eat? High chair / Booster / Table:

How independently does your child eat and use utensils?

What kind of drinking cup does your child use?

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 toilet trained, are diapers or training pants used?

Any skin sensitivities or diapering concerns?

Personal-care products to use or avoid?

Any bowel-movement routines or concerns?

Any constipation, diarrhea, or other toileting concerns?

If toilet trained, what type of toilet or seat does your child use?

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

Is your child ever reluctant to use the bathroom? _

If applicable, how often do toileting accidents occur?

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

_

Sleeping Habits

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

Does your child sleep in a bed, crib, or another arrangement?

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

If so, how long? __

For children under 12 months, safe sleep procedures follow applicable infant-care requirements.

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)_

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?

Response to unfamiliar people or situations?

Independent and group play?

Favorite Toys, Animals, etc.? __

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

How do you comfort your child?_

How do you support your child when upset?

What would you most like your child to gain from school?

Daily Schedule

Please describe a typical day: waking, meals, toileting, rest, and bedtime.

Other information (transitions, sensory needs, supports):

Parent Name & Signature

Print Name: Date:

Last *First*

Signature: