CHILD HISTORY FORM

Child Information

Child's Full Name:
Date of Birth:

Previous Schooling

Has your child previously attended a nursery/daycare?
☐ Yes ☐ No

If yes, how was your child's experience?

Separation From Parents

Has your child been separated from the parents until now?

a) Daily, in the case where both parents work

- From what age: _____
- Continuous or occasional: _____

b) If the parents were away for a period of months for various reasons (transfer, training, health, etc.)

Who cared for the child in these cases?
☐ Grandmother ☐ Grandfather ☐ Other relatives ☐ Other caregiver
Details: _____

Siblings (gender & ages):

Other people living in the home who care for the child:

Do you feel the time you share with your child is sufficient (for both you and the child)?

Child's Interests & Socialization

Favorite activities / hobbies:

Does your child interact with other children (family, friends, neighborhood)?
☐ Yes ☐ No

If yes, how often?

Language

If one parent is a foreign-language speaker:

- Language used at home: _____
- Does the child learn both languages? ☐ Yes ☐ No

Life Events

Has the child experienced serious illness or the loss of a loved one?
☐ Yes ☐ No

Home Environment

Does the child have their own room?
☐ Yes ☐ No

Media Use

Does the child watch television?
☐ Yes ☐ No

If yes, how long and what type of programs?
☐ Children's shows ☐ Adult series ☐ News ☐ Other: _____
Duration: _____

Behavior at Home

Strengths & Expectations

Positive qualities of the child:

Areas where the child faces difficulties:

What areas of development do you emphasize most as your child enters school?

What are your expectations from the school?

AUTONOMY

Does the child wear a diaper?
☐ Yes ☐ No

If no, age of toilet training: _____

Occasional accidents (urine or stool)?

Does the child need help using the toilet?
☐ Yes ☐ No

Age of first words: _____
Age of good verbal communication (short sentences): _____

NUTRITION

Does the child eat independently?

☐ Yes ☐ No

Behavior at the table:

Special eating habits:

Allergies:

SLEEP

The child sleeps:

☐ Alone ☐ With others ☐ With light on ☐ Midday nap

Is there a sleep routine?

Does the child need someone to fall asleep? Who?

Does the child need an object to fall asleep?

Sleep quality:

☐ Normal ☐ Nightmares ☐ Fears ☐ Sleepwalking

Details: _____

HEALTH

Has the child needed hospitalization? At what age and for how long?

Childhood illnesses the child has had:

Any health condition requiring attention from the school pediatrician or educator?

Any special needs the educator should be aware of?

Anything else you consider important: