DEDHAM PUBLIC SCHOOLS
DEVELOPMENTAL HISTORY (Confidential)

Please contact school if you would prefer to discuss this information in person

Child's Name::_____ Date:_____

Date of Birth: _____ Age:_____ Sex: _____

Address: _____

Parent/Guardian Name:_____

Address:_____

Home Phone: _____ Cell:_____ Work :_____

Email:_____

Parent/Guardian Name:_____

Address:_____

Home Phone: _____ Cell:_____ Work:_____

Email:_____

Siblings: _____ No _____ Yes - If yes, list below.

Name:_____ Age:_____ School:_____ Living at home?_____

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With whom does the child live?_____

Does this child have any step parents? No/Yes (circle one) If yes, complete the following:

Name:_____

Address:_____

Name:_____

Address:_____

Childcare/Educational History:

Childcare?_____No_____Yes - Where and how long?_____

Preschool?_____No_____Yes - At what age?_____ Days per wk_____Where?_____

Any concerns in preschool?_____

Kindergarten?_____No___Yes - Where and how long?_____

_____Full Day _____Half Day Any concerns?_____

Does your child have additional caregivers: _____ No _____ Yes, If so, list below:

Name:_____ Phone:_____

Social Relationships:

How would you describe your child? *(interests, strengths, weaknesses, personality, etc)*

_____

_____

How do you think your child feels about school?_____

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

_____

Does your child have friends his/her own age?_____No_____Yes

What role does your child take on with peers? (leader, aggressor, passive, etc.)?_____

Reaction to strangers:_____ Able to play alone?_____

Favorite toys and activities: _____

Fears (the dark, animals, etc.):_____

How do you comfort your child?_____

What is the method of behavior management/discipline at home?_____

_____

Milestones:

Birth weight: _____lbs _____oz Length of pregnancy:_____

Conditions of pregnancy & delivery (complications, unremarkable, etc)

_____

Talking:_____ Walking:_____ Toilet Trained:_____

Does your child experience any of the following difficulties? (Circle and explain if yes)

Walking No/Yes_____

Speech (unclear) No/Yes_____

Feeding problem No/Yes_____

Underweight No/Yes_____

Overweight No/Yes_____

Colic No/Yes_____

Difficulty sleeping/ night terrors: No/Yes_____

Difficulty riding a bike: No/Yes_____

Difficulty skipping: No/Yes_____

Difficulty throwing/catching: No/Yes_____

Sleep in their own bed? No/Yes_____

Dress self? No/Yes_____

Separation issues? No/Yes_____

DAILY SCHEDULE

Please describe your child's schedule on a typical day.

_____

_____

Describe any special characteristics or needs (stuffed animal, story)mood upon waking etc.

_____

Is your child involved in any organized group activities? If so, please list:_____

_____

HEALTH

Please list any significant illnesses/operations/emergency room visits):

_____ Age:_____

_____ Age:_____

_____ Age:_____

_____ Age:_____

Pediatrician name and telephone number:_____

Any known complications at birth? _____

Any regular medications? (more than 3 months): _____No _____Yes, detail below:

Name of medication:_____ Date started:_____

Reason for this medication:_____

Name of medication:_____ Date started:_____

Reason for this medication:_____

Name of medication:_____ Date started:_____

Reason for this medication:_____

<u>Has your child ever experienced:</u>

Asthma?***** No/Yes_____

*****If yes, is asthma controlled? (explain) _____

Allergies? No/Yes_____

Ear Infections? No/Yes_____

Ear tubes? No/Yes_____

Hearing problems? No/Yes_____

****Asthma Action Plan from your pediatrician will be required before your child can start school.***

Has this child ever been involved with any other specialists? _____No _____Yes

If yes, please explain:_____

Special physical conditions, disabilities:_____

_____

Any concerns with vision or hearing?:_____

Allergies: (i.e. hay fever, insect bites, medicine, food reactions):

_____

_____

Has your child been involved in counseling or therapy? _____No _____Yes

Reason for counseling:_____

_____

Family history of learning difficulties or learning disabilities? _____No_____Yes, explain below:

_____

_____

Any significant life changes or losses?_____No_____Yes, explain below:

_____

_____

Any concern(s) about your child's academic, social, and or emotional development?

_____

_____

EATING HABITS

Special characteristics or difficulties: _____

Favorite foods: _____

Foods refused: _____

Does your child eat with a spoon? _____ Fork?_____ Hands?_____

TOILET HABITS

Toilet trained_____Yes _____No, If no - Attempted_____

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

Is there a problem with diarrhea?_____ Constipation? _____

Please describe any particular procedure to be used for your child at school:

_____

What is used at home? Potty Chair? _____ Special child seat? _____ Regular seat? _____

How does your child indicate bathroom needs (include special words): _____

Is your child ever reluctant to use the bathroom? _____

Does your child have accidents? _____

Diaper Use:_____Not applicable to my child (If applicable, complete below:

Are disposable or cloth diapers used? _____Frequent occurrence of diaper rash?_____

Do you use: oil:_____ powder:_____ lotion:_____ Other:_____

Is there anything else we should know about your child?

_____

_____

_____

_____ Date:_____

Parent/Guardian Signature

Print Name: _____