Infant and Toddler Health History
(To be completed by parent before admission)

The purpose of securing this information about your child is to help the Visitation Childcare Center staff better understand your child and more easily meet your child's needs.

Child's Name: ________________________ Birth Date: ________________ Date: ___________
Nickname: ______________________

Section A: Health History:

1. Does this child seem healthy most of the time?……………………………………………………………… □ Yes □No
2. Is child taking any medicines now (including aspirin, laxatives, vitamins, etc)? ………………….. ……… □ Yes □No
   If yes, what? ________________________ Why? ___________________________
3. In the last year, has this child had as many as three (3) ear infections? …………………………………… □ Yes □No
4. Are you concerned about this child's hearing? ………………………..……………………………………□Yes □No
5. In the last year, has this child had more then three (3) colds or sore throat infections with a fever? ……..…. □Yes □No
6. Are you concerned about your child's eyes or vision?……………………………………………………….. □Yes □No
7. Has your child been seen by a medical specialist other then their regular MD?……………………………… □Yes □No
8. What arrangements have you made for the care of your child should he/she become ill at the center?
   ____
9. Does your child have any special needs?……………………………………………………………….. □Yes □No
   Describe: ____
10. Other illnesses or diseases?…………………………………………………………………………….. □Yes □No
    If yes, what? ____
11. Has this child been hospitalized?………………………………………………………………….… □Yes □No
    Describe: ____
12. Has this child had any serious accidents or poisonings?……………………………………………….. □Yes □No
    If yes, what? ____
13. Does this child chew unusual things like pencils, chalk, cribs, window ledges, paint chips, plaster or hair? □Yes □No
14. Has your child had any of the following (please circle)?
    Premature Birth   Birth Injury or Defect   Trouble Breathing at Birth   Convulsions/Seizures   Head Injuries
    Allergies: Eczema, hives, drug/food intolerance, hay fever, wheezing, asthma, insect stings or reactions
    Describe: ____
    ____

Section B: Developmental History

1. How do you comfort your child? ____
   ____
2. What are your child's favorite toys? ____
3. What are your child's favorite activities? _____________________________________
4. What languages are spoken in the home? _____________________________________

Section C: Sleeping History

1. Do you have any special way of helping your child go to sleep? ……………………………………………□Yes □No
   If yes, what? ____
   ____
2. Does your child cry when going to sleep? ……………………………………………………………….. □Yes □No
3. What is your child's present sleeping schedule?
4. Does your child prefer to sleep on his/her: □ Stomach □ Side □ Back