# GSA Child Development Form

Today's Date _____

Child's Full Name _____ Date of Birth _____

Nickname _____ Gender: M F

## Health

1. Is your child currently taking any medications? Yes No (Including aspirin, laxatives, vitamins, etc.)

If yes, what? _____ Why? _____

2. What arrangements have you made for the care of your child should he/she become ill at the center?

_____

_____ 3. Does your child

have any special needs or disabilities? Yes No

If yes, please describe: _____

4. Has your child ever been hospitalized? Yes No
If yes, please describe: _____

5. Does your child chew on unusual things such as cribs, window ledges or hair? Yes No

If yes, please describe: _____

8. Has your child had any of the following? (Please Circle.)

Premature birth

Birth injury/Defect Convulsions/Seizures

Trouble breathing at birth Head Injury

Allergies (including eczema, hives, drug, food intolerance, hay fever, wheezing, asthma, insect stings)

If yes, please describe: _____

## Development

How is your child best comforted? _____

What are your child's favorite activities? _____

_____

What is the primary language(s) spoken in your home? _____

## Sleeping

Please describe any specific ways in which you help your child to fall asleep:

_____

_____

What is your child's current sleeping schedule?

| Morning Nap | | Afternoon Nap | | Nighttime | |
|---|---|---|---|---|---|
| **Start** | **End** | **Start** | **End** | **Start** | **End** |
| | | | | | |
| | | | | | |
| | | | | | |

Does your child use a pacifier at naptime? Does your child use a special toy at naptime? Does your child use a blanket at naptime?

_____

_____

## Toileting

How frequently does your child have a bowel movement? _____

Does your child have diaper rash often? Yes No

If so, how is it best treated? _____

## Additional Information

_____

_____