Last Name: First Name: DOB:

Gardner Public Schools

Developmental History Form
Updated: March 2022

STUDENT INFORMATION			
Last Name	First	M.I.	Today's Date
Date of Birth	Place of Birth	Preferred Name	
Emergency Contact Name	Emergency Contact #	Relationship to Child	
Child Lives With ☐ Both Parents ☐ Mother ☐ Father	Other person(s) living in the home		
Child's Legal Guardian(s) **if** other than both parents			
Please note any legal restraining issues currently active regarding this **child** and attach documentation			
Name of Individual filling out this form	Relationship to Child		

PARENT INFORMATION			
Parent/Guardian 1 Last Name	Parent/Guardian 1 First Name		
Parent/Guardian 1 Address			
City	State	Zip	Primary Phone
Date of Birth	Place of Birth	Last Grade Completed	
Occupation	Place of Employment	Work Phone	
Parent/Guardian 2 Last Name	Parent/Guardian 2 First Name		
Parent/Guardian 2 Address			
City	State	Zip	Primary Phone
Date of Birth	Place of Birth	Last Grade Completed	
Occupation	Place of Employment	Work Phone	

EDUCATIONAL HISTORY			
Has your child previously attended a preschool program? YES NO	If yes, name of program		
Dates Attended	Hours Per Day	Days Per Week	
I, the parent/legal guardian of the above named child, give permission for the Gardner Public Schools to review my child's previous written school records and/or talk to his/her formers teacher(s).	Parent/Guardian Signature		
Please check any of the services your child receives IEP 504 Speech DCF Early Intervention			

FAMILY HISTORY	
Is there a family history that may affect this child's adjustment to school? (Please check and comment for applicable family event.)	
☐ Adoption	Comments:
☐ Foster Placement	Comments:
☐ Parent-Child Separation	Comments:
☐ Other	Comments:
Sibling Information:	

Last Name: First Name: DOB:

Name	Gender	DOB	Health	Lives in Home ☐ YES ☐ NO
Name	Gender	DOB	Health	Lives in Home ☐ YES ☐ NO
Name	Gender	DOB	Health	Lives in Home ☐ YES ☐ NO
Name	Gender	DOB	Health	Lives in Home ☐ YES ☐ NO

Has an older sibling demonstrated difficulty in school? If yes, please describe. ☐ YES ☐ NO

Comments:

Has this sibling ever received special services for any of the following? (Please check and comment for applicable services.)

☐ Speech	Comments:
☐ Emotional	Comments:
☐ Physical Disability	Comments:
☐ Developmental Delays	Comments:

DEVELOPMENTAL MILESTONES

At what age did your child first:	Sit?	Walk?	Toilet Trained Day?
Toilet Trained Night?	Use Single Words?	Use Sentences?	Sleep Through the Night?

Has your child eaten any non-food products such as paint, dirt, pencils, paper, etc.? If yes, please explain. ☐ YES ☐ NO

Comments:

Has your child displayed any unsafe behaviors such as ingestion of pills/medication, darting **into** road, fire setting, etc.? If yes, please explain.
☐ YES ☐ NO

Comments:

SOCIAL DEVELOPMENT

Please indicate this child's preferences regarding play and social interaction. (Check all that would apply.)

☐ Solitary Play	☐ In Groups	☐ With Older Children
☐ With Younger Children	☐ Own Age Group	☐ No Preferences

Describe child's relationships with his/her:	Father
	Mother
	Siblings
	Other Family Members

Does this child relate easily to non-family children and adults? ☐ YES ☐ NO

Comments:

Does this child have any serious fears or phobias? ☐ YES ☐ NO

Comments:

Difficulty Sleeping?	Restless Sleeper?	Snore?
Grind Teeth?	Sleep Walk?	Night Terrors?

Is there anyone in your family who has experienced seizures or other neurological problems? ☐ YES ☐ NO

Comments:

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Is there anyone in your family who has had attention difficulties? ☐YES ☐NO			
Comments:			
Is there any significant medical or mental health issue with any member of your family? ☐YES ☐NO			
Comments:			
Do you have any behavioral concerns for your child? ☐YES ☐NO			
Comments:			
Has your child ever engaged in counseling or therapy? ☐YES ☐NO			
Comments:			

MEDICAL HISTORY

Prenatal – Check all that occurred during the pregnancy for **this** child:

☐Excessive Weight Gain (>25lbs.)	☐Poor Weight Gain (<10 lbs.)	☐Bleeding or Spotting	☐Toxemia/High Blood Pressure
☐Gestational Diabetes	☐Exposure of mother to measles, mumps, or chicken pox while pregnant		

Delivery – Check all that occurred during the delivery of **this** child:

☐Spontaneous Labor (Began on its own)	☐Induced Labor	☐Vaginal (Head First) Delivery
☐Vaginal (Feet First) Delivery	☐Forceps Delivery	☐Cesarean Delivery*

*If Cesarean Delivery, was it due to fetal distress (the baby was having trouble)? ☐YES ☐NO

Neonatal – Check all that occurred during the newborn stage for **this** child:

☐Supplemental Oxygen Required	☐Premature Delivery (_____weeks early)	☐Severe Yellow Jaundice, Blue Spells
☐Newborn Convulsions/Seizures	☐Born with Medical Problem (i.e. cerebral palsy, cystic fibrosis, etc.)	

Comments:

Child's Due Date	Child's Birth Weight	Spent_____Days in Hospital as a Newborn

Summary of Child's Applicable Medical Status (Please check and comment for all that apply.)

☐Respiratory Condition (i.e. asthma, bronchitis)	Comments:
☐Chronic Skin Condition (i.e. eczema)	Comments:
☐Neurological Condition (i.e. seizures, ADHD)	Comments:
☐Medications Taken Regularly	Comments:
☐Hay Fever, Pollen, Seasonal Type Allergies	Comments:
☐Allergy (food, bee sting, touch, medication)	Comments (list specific allergy and treatment required):
☐Hearing Difficulties; Are Hearing Aides Used?	Comments:
☐Frequent or Recurrent Ear Infections	Comments:
☐Vision Difficulties; Appearance of Crossed Eyes	Comments:
☐Are Glasses or Eye Patch Worn?	Comments:
☐Dental/Swallowing/Chewing Difficulties	Comments:
☐Muscular/Skeletal Condition	Comments:
☐Brace/Corrective Shoes Worn?	Comments:

BASIC ACTIVITIES OF GROWING AND DEVELOPING

Last Name: First Name: DOB:

Can this child (check all that apply):	☐ Use Spoon and Fork to Eat Without Spilling?	☐ Wash and Dry His/Her Own Hands?
☐ Dress Him/Herself?	☐ Do Buttons?	☐ Be Left at Daycare or Babysitter without a Big Fuss?
Does this child have (check all that apply):	☐ Any Eating Difficulties?	☐ Any Problems Sleeping?
☐ Problems with Nightmares or Night Terrors?	☐ Frequent Nosebleeds?	

Is your child dependably toilet trained, with only rare accidents? ☐ YES ☐ NO

Does this child enjoy (check all that apply):

☐ Playing Active Group Games (i.e. tag)?	☐ Playing Quiet Group Games (i.e. checkers)?	☐ Playing Independently and Alone?

Does your child play alone without direct adult supervision? ☐ YES ☐ NO

Does this child (check all that apply):	☐ Play Successfully with Puzzles, Blocks and Other Construction Toys without Help?	
☐ Write and Draw Rather than Scribble?	☐ Hold a Pencil Properly?	☐ Prefer Right Hand? ☐ Left Hand? ☐ Both?
☐ Trip and Fall Easily?	☐ Run Into Things?	☐ Have Difficulty Climbing or Descending Stairs?
Can this child (check all that apply):	☐ Ride a Tricycle?	☐ Throw and Catch a Ball?
Do you consider this child to be (check all that apply):		☐ Highly Active?
☐ Very Quiet or Shy	☐ Generally Happy?	☐ Generally Sad?
Does this child (check all that apply):	☐ Cry Easily?	☐ Demonstrate Frequent Temper Tantrums?
☐ Usually Follow Directions?	☐ Have a Very Short Attention Span?	☐ Frighten or Startle Easily?

Did your child start to speak significantly later than other children of the same age? ☐ YES ☐ NO

Is your child (check all that apply):	☐ Able to Speak Most Sounds Correctly?
☐ Afraid or too Shy to Speak Up?	☐ Understandable to Others Unfamiliar with His/Her Speech?

Does this child (check all that apply):	☐ Turn Up the TV Volume Excessively Loud?	☐ Say "What, What?" All the Time?
☐ Sit Extremely Close to the TV Screen?	☐ Hold Pictures or Drawings Close to See Them?	☐ Often Repeat Sounds or Words/ Stutter or Stammer?

Early Childhood Education Experience Survey

Please check next to the option that best describes your child's preschool experience in the school year prior to entering Kindergarten. Select one option only, and indicate hours where applicable. Thank you!

Name of child:_____ Date of Birth:_____

☐ My child did not have any formal early childhood program experience

☐ My child did not have formal early childhood program experience but participated in Coordinated Family and Community Engagement (CFCE) services.

☐ My child did not have formal early childhood program experience but participated in Parent Child Home Program (PCHP) services.

☐ My child did not have formal early childhood program experience but participated in **BOTH** Coordinated Family and Community Engagement (CFCE) **AND** Parent Child Home Program (PCHP) services.

☐ My child attended a Licensed Family Child Care Provider **(indicate hours below)**

- ☐ for less than 20 hours per week
- ☐ for 20+ hours per week

☐ My child attended a Center Based Program **(indicate hours below)**

- ☐ for less than 20 hours per week
- ☐ for 20+ hours per week

☐ My child attended **BOTH** a Licensed Family Child Care Provider **AND** a Center Based Program **(indicate hours below)**

- ☐ for less than 20 hours per week
- ☐ for 20+ hours per week

Definitions:

Coordinated Family and Community Engagement (CFCE) Services: locally based programs serving families with children birth through school age (e.g. parent/child playgroups, parent-child activities).

Parent Child Home Program (PCHP): home visiting model program funded through the Department of Early Education and Care.

Licensed Family Childcare**:** refers to EEC licensed child care in a group setting in a home. It may include care in the home of a family member, if the provider is both a relative and an EEC licensed child care provider providing care to children from multiple families.

Center-Based Care: refers to care for children in a group setting, including public and private preschools, Head Start, day care centers, and integrated public preschools.