Your future begins here.
Region 14 Schools
Serving the Towns of Bethlehem and Woodbury

Preschool Developmental History

Please return completed form. Date: _____

I. General Information

Child's Name _____

Date of Birth: _____ Gender: M F

Address: _____ Phone: _____

_____

Information given by: _____

Relationship to child: _____

Father's Name: _____ Phone_____

Mother's Name: _____ Phone _____

Emails both parents _____

Brothers and Sisters: Age

1. _____ ____
2. _____ ____
3. _____ ____
4. _____ ____
5. _____ ____

Please tell us what has prompted you to have your child participate in the Integrated Preschool Program?

_____
_____
_____
_____
_____
_____
_____

II. Areas of Concern

Please place a check next to any behavior or problem that this child currently exhibits and explain:

_____ has difficulty with speech (pronouncing sounds/words)

_____ has difficulty with language (putting words together)

_____ has difficulty following directions, listening, and attending

_____ has difficulty with hearing

_____ has difficulty with vision

_____ appears awkward and uncoordinated

_____ trips or falls often

_____ has difficulty with toilet training

_____ has sleep problems

_____ has eating problems (for example: chokes, gags, overstuffs, poor chewing, fussy eater)

_____ drooling is noticed

_____ has frequent tantrums

_____ appears more active than children his/her age

_____ appears tired or weak

_____ is impulsive

_____ unusually sensitive to noise or sudden movement

_____ is considered discipline problem at home or school

_____ has difficulty learning

_____ has difficulty playing with other children

_____ avoids different tactile experiences (i.e. sand, grass, water, Playdoh)

III. Medical History

1. Pregnancy and Birth (If adopted or foster, check here _____)

Length of pregnancy: _____ Birth weight: _____

Please check the appropriate column	Yes	No
Use of medication/drugs during pregnancy		
Received regular prenatal care		
Labor lasted longer than 12 hours		
Labor lasted less than 2 hours		
Had a caesarian section		
Other _____		

Did this child present any of the following problems at birth?	Yes	No
RH incompatibility		
Yellow or jaundiced		
Convulsions		
Cerebral Palsy		
Cleft lip or palate		
Need for oxygen		
Feeding, sucking, swallowing problems		
Blood transfusions		
Chemical dependency		
Other _____		

2. List any medications used over a long period of time:

_____

3. List any medications currently being used:

_____

4. Who is the child's current pediatrician?

_____

5. Date of most recent physical exam: _____

Please check the appropriate column	Yes	No
Allergies		
Neurologist		
Ear, nose, throat		
Orthopedist		
Speech Therapist		
Occupational Therapist		
Physical Therapist		
Ophthalmologist		
Optometrist		
Psychiatrist/psychologist		
Educator		

IV. Health

	Never	0-6m	6-12m	12-18m	18-24m	2-3yrs	3-4yrs	4-5yrs
Measles								
German Measles								
Mumps								
Chicken Pox								
Meningitis								
Encephalitis								
High Fever								
Convulsions								
Allergy								
Injuries to Head								
Ear Problems								
Visual Problems								
Epilepsy								
Jaundice/Hepatitis								
Heart Disease								
Asthma								
Bleeding Problems								
Slow Weight Gain								

List and describe any hospitalizations, operations, or accidents:

_____

_____

_____

V. Developmental Milestones

	0-3m	4-6m	7-12m	13-18m	19-24m	2-3yrs	3-4yrs	4-5yrs	Not yet
Rolled over									
Sat alone									
Crawled									
Walked alone									
Walked upstairs									
Rode a tricycle									
Caught a big ball									
Babbled									
Spoke first word									
Put words together									
Talked in sentences									
Speech clearly understood by others most of the time									
Able to respond to simple commands									
Used fingers to feed self									
Explored playground equipment									

VI. Play Information

Please provide an explanation for any yes answer.

1. Does the child currently attend preschool?

2. Does the child regularly attend community group activities (i.e. church, library, gymnastics)?

3. Does the child routinely play with other children?

4. Do you have any concerns regarding the way your child interacts with his/her peers?

5. Do you have any concerns regarding the way your child interacts with family members (i.e. siblings, cousins)?

6. What are the child's favorite toys or activities?

7. Please add any information which you feel may help us in working with this child.