Andrews University
Children's Learning Center

Infant Developmental History Form

Baby's Name: ..... Date of Birth: .....

What would you like us to call your baby? .....

Does your baby speak English? ☐ Yes ☐ No

Is any language other than English spoken in your home? ☐ Yes ☐ No

If yes, what languages are spoken at home? .....

Parent/Guardian Name: .....

Parent/Guardian Name: .....

Does the baby's father live in the same home as the baby? ☐ Yes ☐ No

Does the baby's mother live in the same home as the baby? ☐ Yes ☐ No

Is there a step-parent in the home? ☐ Yes ☐ No

Is your baby adopted? ☐ Yes ☐ No If yes, age of adoption _____ If yes, does baby know he/she is adopted? ☐ Yes ☐ No

Name of Person Completing Form: .....

In the columns below list the names of family members residing with the baby. Please include siblings, extended relatives, and pets. For each person listed provide the name the baby uses to address that individual and include ages of siblings.

Name	How baby addresses this individual?	Age

Please list words in your language corresponding to the English below.	
I'll take good care of you	
I see that you are crying	
Time to go outside	
I like your smile	
Time for snack/lunch	
Everyone is resting now	
Daddy will be back	
Mommy will be back	
Let's change your diaper	

If parental custody is shared, describe the custody arrangements: .....

.....

.....

Please tell us about cultural family customs, rituals, or traditions that will help us make your baby's experience more meaningful, including languages spoken at home: .....

.....

.....

DEVELOPMENTAL HISTORY

Age Baby Began: Sitting: _____ Crawling: _____ Standing: _____ Walking with support: _____

Walking independently: _____ Cooing: _____ Babbling: _____

Saying audible words:_____ Saying 2 or 3 simple sentences: _____

Do you have developmental concerns about your baby? .....

.....

.....

How does your baby communicate his/her needs? .....

.....

.....

CHILD'S HEALTH

List medications regularly taken and conditions requiring them: .....

.....

.....

.....

Describe serious illnesses or hospitalizations:.....

.....

.....

.....

Describe special physical conditions, disabilities, allergies, or concerns: .....

.....

.....

.....

Does your baby have a special need? .....

.....

.....

.....

Explain special services and accommodations, which are different from those provided by the center's routine program (i.e. exercises, equipment, materials, or special services personnel): .....

.....

.....

.....

Does your baby have frequent stomach aches? ☐ Yes ☐ No vomit easily? ☐ Yes ☐ No

Does your baby run high fevers easily? ☐ Yes ☐ No

NUTRITION PRACTICES AND ROUTINES

How is your baby fed? (Check all that apply): ☐ Breast ☐ Bottle ☐ Cup

Does your baby know how to drink from a bottle? ☐ Yes ☐ No If no, explain your plans to help them achieve this: .....

.....

.....

In the corresponding row, provide your baby's feeding details.

	Brand	Amount	Preferred time of day given
Formula/Milk			
Breast Milk			

If your baby is exclusively breast fed, please outline your daily plan: :.....

.....

.....

If your baby is breast fed or receiving expressed breast milk, how can we support you?.....

.....

.....

Does your baby have any eating difficulties? ☐ Yes ☐ No If yes, explain:.....

.....

List special dietary requests^, food allergies^ and restrictions^ (^Doctor signed form required):.....

.....

.....

Have solid foods been introduced? Yes No If yes, please identify: .....

.....

.....

Are there any foods you do not feed your baby? .....

Does your baby have strong food likes or dislikes? .....

.....

Do you or will you feed your baby? (choose all that apply)

Eggs ☐ Yes ☐ No^ (^Doctor signed form required.)

Cheese ☐ Yes ☐ No^ (^Doctor signed form required.)

Dairy ☐ Yes ☐ No^ (^Doctor signed form required.)

Soy ☐ Yes ☐ No^ (^Doctor signed form required.)

Baby eats with: ☐ Spoon ☐ Fork ☐ Fingers ☐ Other .....

Baby is fed in: ☐ Highchair ☐ In Arms ☐ Bouncy seat ☐ Other .....

Preferred time of day to feed baby: _____ A.M. _____ A.M. _____ P.M. _____ P.M.

SLEEPING ROUTINES

Pre-nap routines/rituals: .....

.....

Number of naps daily: _____

From: _____ To: _____ From: _____ To: _____

From: _____ To: _____ From: _____ To: _____

From: _____ To: _____ From: _____ To: _____

Preferred sleep position*: .....

At home baby sleeps in (Check all that apply): ☐ Bassinet ☐ Crib ☐ Bed

Baby's typical waking behavior/routine/mood: .....

.....

.....

Special sleeping concerns:.....

.....

* Note: The Crayon Box places infants to sleep on their backs in crib unless an infant cannot rest or sleep on her or his back due to disability or illness and written instructions, signed by the infant's licensed health care provider, detailing an alternative safe sleep position or other special sleeping arrangements for the infant must be followed and kept on file at the center. The instructions must include an end date. Following the recommendation of the American Academy of Pediatrics, soft items such as bumpers, stuffed animals (including pacifiers with a stuffed animal attached), blankets and quilts are not allowed in cribs.

DIAPERING/TOILETING ROUTINES

Please check which type of diapers you will provide: ☐ disposable ☐ cloth* (*see handbook for policy on cloth diapers)

Words used for urination: .....

Words used for bowel movement: .....

COMFORTING CHILD

Position baby prefers to be held: .....

Security object (if any): ..... Name baby uses for object/when needed: .....

.....

.....

Does your baby use a pacifier? ☐ Yes ☐ No If yes, when: .....

Describe how adults can comfort your baby? .....

.....

.....

.....

.....

Security object (if any): ..... Name baby uses for object/when needed: .....

.....

.....

SOCIAL RELATIONSHIPS

Describe your baby's temperament: ☐ Determined ☐ Outgoing ☐ Shy ☐ Relaxed ☐ Assertive Explain: .....

.....

.....

How does your baby react to new situations and new children and adults? .....

.....

.....

Has your baby had previous child care experience? ☐ Yes ☐ No If yes, explain how it met, or did not meet, your expectations? .....

.....

.....

Baby's favorite indoor play activity .....

Baby's favorite outdoor play activity .....

Is your baby frightened by any of the following? ☐ animals ☐ dark ☐ storms ☐ loud noises ☐ bugs ☐ other .....

Please describe how your baby acts in a group play situation. (Check all that apply)

- ☐ Nervous, worried
- ☐ Pushy, bullies others
- ☐ Social, friendly
- ☐ Gets angry easily
- ☐ Hyper, restless, can't sit still
- ☐ Relaxed, calm
- ☐ Shy, withdrawn, keeps to self
- ☐ Scared, fearful

.

ADDITIONAL PERTINENT INFORMATION

Is there additional information you feel is important for the staff to know about your baby or family? .....

.....

.....

What do you as a family, hope to get out of this child care experience?.....

.....

.....

Parent/Guardian Signature: ..... Date: .....

Staff Signature: ..... Date: .....

Sections of this Personal Care Plan will be updated every 3 months or sooner if requested by a parent/guardian.

Date of Change:		Parent Initials:		Staff Initials:	
Date of Change:		Parent Initials:		Staff Initials:	
Date of Change:		Parent Initials:		Staff Initials:	
Date of Change:		Parent Initials:		Staff Initials:	
Date of Change:		Parent Initials:		Staff Initials:	
Date of Change:		Parent Initials:		Staff Initials:	
Date of Change:		Parent Initials:		Staff Initials:	
Date of Change:		Parent Initials:		Staff Initials:	