

ST. THOMAS AQUINAS EARLY CHILDHOOD CENTER
CHILD HEALTH AND DEVELOPMENT QUESTIONNAIRE
(To be completed by parent or guardian)

Child's Full Name _____ Date _____

Date of Birth _____ Race _____ Sex _____

Name of Parent or Guardian completing form _____

PLEASE MAKE SURE YOUR CHILD'S PHYSICAL AND IMMUNIZATION FORMS ARE ON FILE IN THE EARLY CHILDHOOD OFFICE WITHIN TWO WEEKS OF THE START OF SCHOOL.

As a supplement to the Student Physical Examination, please answer the questions on this form. We feel this information will help us be more effective in working with your child.

Childhood diseases child has had:

	Date		Date
_____ Chicken Pox	_____	Rheumatic Fever	_____
_____ Measles ___ 3 day (Rubella)	_____	Mumps	_____
_____ Measles ___ 10 day (Rubeola)	_____	Strep Throat	_____
_____ Scarlet Fever	_____		

Is your child taking over-the-counter or prescribed medication regularly at home? Yes _____ No _____
If yes, what? _____

Is your child taking vitamins regularly at home? Yes _____ No _____
If yes, what? _____

List any known allergies to food or environment _____
What is the allergic reaction? _____

Does your child complain of feeling ill often? _____

Have you ever suspected your child of having seizures (fits)? _____

Describe your child's appetite _____

Does your child dislike any foods? _____ If so, what? _____

What does your child usually eat for breakfast before arriving at the center? _____

How easily does your child fall asleep? _____

What is the usual bedtime? _____ Wake up time? _____

What is the usual naptime? _____ Wake up time? _____

Is your child completely toilet trained? Yes _____ No _____

Does your child remain dry all night? Yes _____ No _____

When did your child begin to walk alone? _____

Are other adults (not family) able to understand the child's speech? _____

Does your child have a regular playmate? Yes _____ No _____ Same age _____ Older _____ Younger _____

What is your child's favorite toy or activity at home? _____

Does your child have temper tantrums? _____

Does your child bite his/her nails? _____ Twist his/her hair? _____

If you could describe your child in one word, what would it be? _____

Please list your child's strong points, such as happy, curious, loving, etc. _____

Is there anything else, medical or otherwise, that we need to know about your child? _____

