



Sugar Grove Developmental Day School  
 P.O. Box 453  
 207 Dale Adams Road  
 Sugar Grove NC 28679



A United Way Agency

### CHILD'S DEVELOPMENTAL HISTORY

Your child's lead teacher will review this form to help the staff better meet the needs of your child. Please take careful consideration while filling this out.

Child's name: \_\_\_\_\_ Child's nickname: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Home phone: \_\_\_\_\_ Cell/other phone: \_\_\_\_\_  
 Birth date: \_\_\_\_\_ Place of birth: \_\_\_\_\_ Race: \_\_\_\_\_

#### Parents or Guardians

A. Name: \_\_\_\_\_ Birth date: \_\_\_\_\_  
 Education: \_\_\_\_\_ Occupation: \_\_\_\_\_  
 Usual working hours: \_\_\_\_\_ Work phone: \_\_\_\_\_

B. Name: \_\_\_\_\_ Birth date: \_\_\_\_\_  
 Education: \_\_\_\_\_ Occupation: \_\_\_\_\_  
 Usual working hours: \_\_\_\_\_ Work phone: \_\_\_\_\_

Status of parents or guardians (please check):  Living together  Living apart  
 Child lives with: \_\_\_\_\_

Who keeps your child in your absence (Check all that apply)?  
 Grandparent(s)  Friend  Sitter  Other \_\_\_\_\_

#### Siblings

NAME	SEX	BIRTH DATE

Others that play a significant part in your child's life and how: \_\_\_\_\_

Has your child been separated from his parents for long periods of time; if so why?  
 \_\_\_\_\_

From your point of view, what are the events that have or will have the greatest impact on your child (moving, divorce, illness, other)? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_



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**DEVELOPMENT**

Does your child usually take a nap?  yes  no  sometimes  other\_\_\_\_\_

If so what is the usual routine:\_\_\_\_\_

Does your child often have:  Diarrhea  Constipation  Other \_\_\_\_\_

List all allergies and any special treatment required:\_\_\_\_\_

Does your child take any medication daily?  yes  no

If so, what kind?\_\_\_\_\_

List any medication(s):\_\_\_\_\_

Has your child had ear/hearing test or treatment:\_\_\_\_\_

Is your child on any kind of special diet?\_\_\_\_\_

Is there any food your child should not eat for medical, religious or personal reasons?\_\_\_\_\_

Does your child eat or chew anything that is not food?\_\_\_\_\_

Does he/she have any trouble chewing or swallowing?\_\_\_\_\_

Comments on health of mother during pregnancy and child during infancy:\_\_\_\_\_

When did your child learn to walk:\_\_\_\_\_Talk:\_\_\_\_\_

Is your child potty trained:  yes  no  other\_\_\_\_\_

If so please comment:\_\_\_\_\_

Does your child have any fears or dislikes:\_\_\_\_\_

Language spoken at home:\_\_\_\_\_

In any circumstance, do you consider your child:

easily managed  fairly easily managed  difficult to manage

Comments or concerns:\_\_\_\_\_

How does your child react in play and social experiences:\_\_\_\_\_

School year:\_\_\_\_\_

Parent(s) Signature:\_\_\_\_\_ Date:\_\_\_\_\_

Parent(s) Signature:\_\_\_\_\_ Date:\_\_\_\_\_