



Medfield Afterschool Program

JUMP START Developmental History & Background Information

CHILD'S NAME: _____ **DATE OF BIRTH:** _____

DEVELOPMENTAL HISTORY: Age began sitting: _____ crawling: _____ walking: _____ talking: _____

Any speech difficulties? _____

TOILET HABITS: Are bowel movements regular? _____ How many per day? _____

Is there a problem with diarrhea? _____ Constipation? _____

How does your child indicate bathroom needs (include special words): _____

Is your child ever reluctant to use the bathroom? _____ Does your child have accidents? _____

EATING HABITS: How would you describe your child's eating habits (times of day, snacking, food preferences/aversions, openness to trying new things, etc...) _____

SLEEPING HABITS: When does your child go to bed at night? _____ and get up in the morning? _____

Does your child become tired or nap during the day (include when and how long)? _____

SOCIAL RELATIONSHIPS: How would you describe your child? _____

Previous experience with other children/day care: _____

Favorite toys and activities: _____

Fears (the dark, animals, etc.): _____

Describe successful behavior management strategies used at home? _____

What would you like your child to gain from this childcare experience? _____

Is there anything else we should know about your child? _____

Previous child care/day care/preschool experience? Yes No Where? _____

Does MAP have your permission for MAP to speak with care providers/teachers? Yes No

Parent/Guardian Signature

Date

Please attach/provide MAP with documentation of a recent physical