UCI Child Care Services
Extended Day Family History Form

949.824.4753

The more the Extended Day staff understands about your child, the better we can meet their individual needs. The goal of the questions is to help our teachers know more about your children in order to plan a curriculum which will provide a balance between home, school, and community activities. This information is confidential, only professional staff will have access to this information.

Date of Entrance _____

FAMILY INFORMATION

Child Information

Last Name:		First Name:	
Birthdate:	Gender:	Place of Birth:	
Street Address:			
City:		State:	Zip:

Parent 1 Information

Last Name:	First Name:	
Email:		Age:
Street Address:		
City	State:	Zip:
Cell Phone#:	Alternate #:	
Affiliation to UCI:	UCI ID:	

Parent 2 Information

Last Name:	First Name:	
Email:		Age:
Street Address:		
City	State:	Zip:
Cell Phone #	Alternate #:	
Affiliation to UCI:	UCI ID:	

What do you hope your child will gain through attending the Extended Day Care Center?

OTHER CHILDREN IN THE FAMILY

Name_____ Age_____

Name_____ Age_____

Name_____ Age_____

Please describe your child's relationship with his/her brothers and sisters._____

OTHER MEMBERS OF THE HOUSEHOLD

Name_____ Age_____

Name_____ Age_____

Describe the relationship your child has with these other members._____

Does your family live in a ☐ house/condo ☐ apartment?

List any moves your family has made and the age of your child when you moved._____

Has your child traveled much? Where? _____

Has your child lived in another country? Where?_____

What language(s) is (are) spoken at home?_____

What language(s) does your child speak and with who?_____

Have there been any deaths, separations or illnesses of family members or friends? If so, please describe your child's reaction._____

FAMILY STRUCTURE

Do both parents live with your child? ☐ yes ☐ no

If not, who does? _____

If only one parent lives with the child, how would you describe your child's relationship with his/her other parent?_____

How often does your child see his/her other parent? How long are the visits?_____

_____

What is the legal custody arrangement?_____

Is your child and/or family in counseling?_____

DEVELOPMENT AND DISCIPLINE

Is your child easy to manage, fairly easy to manage or hard to manage? Explain._____

_____

Does your child have any behavior difficulties that we should be aware of (e.g. tantrums, aggression, extreme shyness, etc.)?_____

What method of discipline have you found to be most effective?_____

_____

How does your child react to being disciplined?_____

_____

Are there any differences of opinion within the family on the management of the child? Explain_____

_____

Does your child have any developmental issues that we should be aware of (e.g., toileting issues, speech problems, etc.)?_____

_____

Are there things that your child really dislikes having done to him/her (tickling, touching, etc.)?_____

_____

Does your child have fears of anything in particular? Explain._____

_____

SLEEPING

Does your child share his/her room?_____With whom?_____

Does your child share his/her bed?_____With whom?_____

What times does your child usually go to bed?_____

Do you have a special bedtime routine? Explain._____

_____

What time does your child usually wake up?_____

What are the ideal number of hours of sleep for your child?_____

Does your child have any sleeping problems (fears, nightmares, etc.)?_____

If so, how have you handled them?_____

MEDICAL HISTORY

If your child has had any of the following diseases, please list the age at which your child had the disease(s):

☐ Chicken Pox _____ ☐ Measles _____

☐ Mumps _____ ☐ Scarlet Fever _____

☐ Whooping Cough _____ ☐ Other illness _____

Were any of these particularly severe? Explain._____

_____

MEDICAL HISTORY

How does your child react when coming down with something?_____

_____

What arrangements will be made when your child is ill and cannot come to the Center?_____

_____

Check any of the following diseases in your family history:

☐ Allergies	☐ Anemia	☐ Asthma Bleeding Disorders
☐ Cancer	☐ Heart Disease	☐ Diabetes
☐ Mental Retardation	☐ Obesity	☐ Rheumatic Fever
☐ Tuberculosis	☐ Seizures	☐ Others _____

MEDICAL

Has your child had any serious illnesses or accidents (especially head injuries)?_____

_____

Has your child ever been hospitalized? _____For how long?_____

At what age and for what reason?_____

_____

How frequently does your child catch a cold?_____

What food(s) is your child allergic to?_____

What is the reaction they have if they ingest the food? _____

Is your child allergic to pets? Which ones?_____

Is your child allergic to anything else? If yes, what and what is their reaction to it? _____

_____

Has your child ever had:

_____Eczema _____Reactions to any medicines or injections

_____Wheezing/Asthma _____Severe reaction to bee stings

If any of these are checked, please explain. _____

_____

Does your child wear glasses or contact lenses?_____

Date of last eye exam_____Results _____

Does your child wear a hearing aid?_____

Date of last hearing exam_____Results_____

When did your child last see the dentist?_____

Any other health problems:_____

Do you have any concerns about your child's health at the present?_____

_____

SCHOOL

School child attends_____

Teacher_____ Grade_____

How is your child doing in school?_____

Does your child enjoy school?_____Explain._____

_____

Does your child have homework?_____How many hours per night?_____

Who helps him/her with homework?_____

Would you like your child to do homework at the Center?_____

What is your expectation about how much homework they will get done at the center?_____

_____

What type of educational activities would you like to see at the Center?_____

_____

SCHOOL

Does your child have any challenges in school? Explain _____

_____

_____

What is your child's favorite subject(s)? _____

What academic area(s) does your child excel in? _____

What academic area(s) are difficult for him/her? _____

How are your child's relationships with peers and teachers? _____

_____

SOCIAL DEVELOPMENT/ PLAY

Does your child watch television?_____How many hours per day?_____

What programs does your child enjoy watching the most?_____

_____

Does your child use the computer, iPad or play video games at home?_____

If so, what games and for how long?_____

Does your child play with other children outside of school? Who (age & gender)?_____

_____

Does your child enjoy playing alone or with a group?_____

What toys and activities is your child interested in?_____

_____

_____

_____

SOCIAL DEVELOPMENT/ PLAY

What activities would your child enjoy at the Center?

- ☐ Art/Crafts
- ☐ Blocks/Building
- ☐ Books/Reading
- ☐ Board games
- ☐ Cooking
- ☐ Dramatic play
- ☐ Drama/Performing Arts
- ☐ Field Trips
- ☐ Music/Dance
- ☐ Science
- ☐ Sports/outdoor games

What interest, hobbies, or talents do you have that you would be willing to contribute to the Center?

_____

_____

_____

COMMENTS/ SUGGESTIONS

_____

_____

_____

_____

_____

_____

Thank you!

Signature_____ Date_____