



NURTURE WITH CARE KIDS ACADEMY

Guiding Tiny Steps into A Bright Future

Email: Info@NurtureWithCareKidsAcademy.com

Phone: (360) 682-8920

Oak Harbor, WA 98277

NurtureWithCareKidsAcademy.com

CHILD HEALTH & HISTORY FORM

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Welcome! We are delighted that you and your child will join us at Nurture with Care Kids Academy. So our staff can make your child's transition as easy as possible, please complete this form. Thank you.

CHILD INFORMATION

Child's Full Name: _____ Birthdate: _____ Age: _____

DEVELOPMENTAL HISTORY

Age child began:

Sitting: _____ Crawling: _____ Walking: _____ Talking: _____

Any difficulties with speaking? ☐ Yes ☐ No

If yes, please explain: _____

DEVELOPMENT AND EARLY SUPPORT

Telling us about a delay, an evaluation, or a therapy does not affect whether we accept your child, and it is not shared with other families. We ask because it changes how we support your child day to day, because it lets us work alongside the people already helping them rather than starting over, and because some support and funding is only available to us if we know. If you are still waiting on answers, tell us that too. We would rather know early.

Do you have any concerns about your child's development? ☐ Yes ☐ No

If yes, please tell us what you have noticed: _____

Has your child been evaluated for a developmental delay? ☐ Yes ☐ No ☐ N/A

If booked or in progress, expected date: _____ Mark N/A above if you are still waiting.

Does your child have an IEP or an IFSP? ☐ Yes ☐ No

If yes, date of the most recent plan: _____ Please give us a copy.

Which of these is your child receiving now? (Check all that apply)

☐ Speech therapy ☐ Occupational therapy ☐ Physical therapy

☐ Early Support (birth to 3) ☐ School district services ☐ Other

Provider or agency: _____ Phone: _____

May we contact the provider above, and your school district, to coordinate care? ☐ Yes ☐ No

May we share our screening results with that provider? ☐ Yes ☐ No

We screen children aged 12 months through 6 years with the ASQ-3. If your child is already being seen by a specialist, tell us so we do not duplicate their work.



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SIBLINGS

Does your child have any siblings? Please list names and ages.

Sibling Name	Age

HEALTH INFORMATION

Have you made special arrangements for your child's care during illness? ☐ Yes ☐ No

If yes, explain: _____

What communicable diseases has your child had? (Check all that apply)

☐ Measles ☐ Mumps ☐ Chicken Pox ☐ Other:

If other, please list: _____

Any physical disabilities? _____ Any known allergies? _____

Any recurrent illness? _____ Your evaluation of health: _____

EATING HABITS

We provide breakfast, lunch, an afternoon snack, and an evening snack for children in care past 5:00 PM, so you do not need to pack food.

Does your child have a food allergy or dietary restriction? ☐ Yes ☐ No

If yes, please describe it and tell us what your child must avoid:

Child's favorite foods: _____

Foods disliked: _____

Does child like: ☐ Cereal ☐ Baby Food

Does child eat with: ☐ Spoon ☐ Fork ☐ Hands

RESTROOM HABITS

Can your child be relied upon to indicate bathroom wishes? ☐ Yes ☐ No

Any fears related to toileting? _____



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Does your child have accidents? ☐ Yes ☐ No

If yes, how often? _____

SLEEPING HABITS

What time does your child awaken? _____ What time is bedtime? _____

Does your child sleep well? ☐ Yes ☐ No

Does your child sleep in their own room? ☐ Yes ☐ No

What time of day does your child nap? _____

SOCIAL DEVELOPMENT

Has your child had experience playing with other children? ☐ Yes ☐ No

How would you describe your child's temperament and personality?

How does your child show their feelings?

What helps your child settle when they are upset?

We ask about guidance at home so we can stay consistent with you, not to judge your choices.

What approaches to guidance work best at home?

Does your child have any special interests?



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MEDICAL INFORMATION

Blood Type: _____ Date of Last Physical Exam: _____

All allergies, including drugs and materials: _____

Chronic illnesses or special health care needs: _____

If your child has a special health care need such as seizures, please bring written instructions from their doctor before their first day, covering what to watch for, what to do, and any medication involved.

Regular Medications: _____

Other pertinent information:

HEALTHCARE PROVIDERS

Child's Physician: _____ Phone: _____

Address: _____

Is your child under regular medical supervision? ☐ Yes ☐ No

Emergency Hospital Preference: _____

Dentist: _____ Date Last Seen: _____

HEALTH INSURANCE INFORMATION (Optional)

Insurance Provider: _____

Member Number: _____ Group Number: _____

Employer: _____

Thank you. This information will be handled confidentially.

Parent/Guardian Signature

Date