

Climbing Tree Community School, an Early Learning Center

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Child Development Information

Child's Name _____
First Middle Last

Has your child had previous experience in preschool or daycare? _____

Please give the age (exact or approximate) at which the following tasks were accomplished

Rolled over both ways _____ Sat up alone _____ Crawled _____
Stood up alone _____ Walked _____ Talked _____
Toilet Training: Started _____ Completed _____

Has your child had the chicken pox: **Yes** **No**

Does your child have any of the following:

_____ Frequent colds	_____ Constipation	_____ Hay fever	_____ Heart Trouble
_____ Frequent earaches	_____ Severe allergies	_____ Diarrhea	_____ Nose bleeds
_____ Stomach upsets	_____ Diabetes	_____ Nightmares	_____ Asthma
_____ Prolonged fevers	_____ Other Medical Conditions	_____	

If yes to any of the above, please explain frequency and circumstance: _____

Do you feel has behavioral or emotional difficulties? _____

Has your child see a specialist for this issue? _____

Name of specialist or physician _____

Does your child have any speech or language difficulties? _____

Has your child see a specialist for this issue? _____

Name of specialist or physician _____

Does your child have any hearing difficulties? _____

Has your child see a specialist for this issue? _____

Name of specialist or physician _____

Is there any other information your child's teacher may find helpful to know about your child's development?

Parent/Guardian Name _____ Date _____