

## INTRODUCE US TO YOUR CHILD

Please introduce us to your child. This information is for the confidential use of the teachers who will be working with your child. Answers beyond yes and no are helpful.

Child's Full Name:		Date of Birth:	
Name called:		<input type="checkbox"/> Female <input type="checkbox"/> Male	
Street Address:		State:	Zip Code:
Mother's Name:		Profession:	
Travel: <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, how frequently?	
Father's Name:		Profession:	
Travel: <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, how frequently?	

## PARENT INFORMATION

<input type="checkbox"/> Married	<input type="checkbox"/> Widowed/How Long?	<input type="checkbox"/> Separated/How Long?	<input type="checkbox"/> Divorced/How Long?
<input type="checkbox"/> Stepmother/How Long?		<input type="checkbox"/> Stepfather/How Long?	
If divorced or separated do you have sole custody or shared custody?			
If child is adopted (optional) Age at adoption:		Does the child know he/she is adopted?	
Comments:			

## SIBLINGS AND FAMILY MEMBERS

Sibling Name:	DOB:	Sex:
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Sibling Name:	DOB:	Sex:
Other members of household and relationship. (Please include full time caregivers and length of service.)		

## SIBLINGS AND FAMILY MEMBERS

If parents are away during the day, please state arrangements for child's care when he/she is not at school:

What are your ideas about toilet training?

## FAMILY LIFE

Family pets:

Family experiences that have influenced your family and child: (Example: A recent move or death.)

What language is spoken at home?

Does your child enjoy a daily reading experience with an adult?

☐ Yes ☐ No

When and with whom does child watch television?

Favorite shows and/or characters?

How much time does your child spend on other electronic devices such as an iPad?

Does child enjoy music?

☐ Yes ☐ No

## DEVELOPMENTAL HISTORY OF CHILD

Approximate age at which your child: Walked:

Repeated short sentences:

Slept through the night:

Completed toilet training:

Does your child show a preference for one hand?

☐ Left ☐ Right ☐ None

## BEHAVIORAL HABITS

Does your child follow a day to day routine?

How does your child react to changes in a daily routine?

Is your child a good eater? ☐ Yes ☐ No

Does the family have mealtimes together? ☐ Yes ☐ No

## BEHAVIORAL HABITS

What time does your child go to bed at night?

Awaken?

Does your child nap? ☐ Yes ☐ No

When?

How long?

Does your child have any special fears?

What causes your child to show her/his temper?

What methods of behavior discipline are used in your home?

## PLAY EXPERIENCES

Has your child had experience playing with other children?

☐ Yes ☐ No

Has your child had experience in full time child care?

☐ Yes ☐ No

Has your child had experience in another pre-school?

☐ Yes ☐ No

Does your child enjoy playing alone?

☐ Yes ☐ No

Your child's favorite indoor play activities:

Does your child have special interests or skills?

Is your child involved in group activities, such as play group, dance, gymnastics, etc?

☐ Yes ☐ No

If yes, please list:

How would you describe your child's personality?

ADDITIONAL INFORMATION

What are your expectations regarding your child's experience at our school?

Is there any other information that you feel is important that the teacher should be aware of?

(Please attach additional information if necessary.)

\_\_\_\_\_  
SIGNATURE OF PARENT COMPLETING FORM

\_\_\_\_\_  
DATE