HELP US GET TO KNOW YOUR CHILD

Linglestown Christian Nursery School

Accredited by the Association of Christian Schools International

CHILD'S NAME: Last_________________________ **First**______________________ Gender: Male Female
Birthday ______________________ Form completed on (date) _________________

Family History

Have there been any significant changes in your child's life in the past year? (e.g. death, separation, new baby, etc.)

Is there any additional information that would help us to relate to your child (e.g. food likes and dislikes, security items, fears, religious or cultural observations, vegetarian, etc.)

Do you practice your religious faith in your home as a family? Read the Bible/holy book? __________
Pray? ________ Any special traditions?

What form of discipline is used in your home? ____

Early Childhood History

Were there any unusual factors or complications during the pregnancy/birth? Yes No
Did your child have any special problems in the first six months? Yes No

What are your expectations/goals for your child this year?

Social History

Can your child transition from one activity to another, follow routines & rules? Yes No

Does your child speak in sentences? Yes No Just a few words? Yes No

How often do you read to your child? ____

Does your child have any experiences playing with other children? What ages?
Other preschool experiences?

Do you have any concerns about your child's:
_______ large motor skills? (climbing, running, walking, etc.)
_______fine motor skills? (holding a crayon ,eating finger foods, grasping objects)
_______sight ______sensory/ sensitivities (touch, light, smells, sounds, etx)
_______hearing
Describe your concerns ____
Are there any particular behaviors you would like us to watch?

Can your child eat with a spoon & fork? Yes No
Does your child drink from a cup without a straw? Yes No

When your child is upset, how do you comfort him or her? ____
What is your child's dominant hand for using pencil, crayons, etc. right left either

Is there any additional information that would help us understand or work more effectively with your child?

General Health History

Has the child ever been in the hospital or had an operation? Yes No
When?_________________ What for?_________________________
Has your child had any other illnesses, accidents, or broken bones? Yes No

Has your child had any trouble with ears or hearing? Yes No

Has your child had any trouble with eyes or vision? Yes No

Do you have concerns about your child's speech or language development? Yes No

Does your child do some things that you find troublesome? Please describe. Yes No

Is your child potty-trained? Yes No
Is your child in ____diapers? ____pull-ups? _____underwear?

Approximately how many hours of sleep does your child get? _______________

Does your child take any medications daily? Yes No If so, list.___________________________________
____