
Date Form Completed

Developmental/Family Information for Pre-Primary

Child's Name _____ DOB _____ Age _____ Gender _____

By what name would you like your child to be called? _____

Home Address _____ Phone _____

Are both parents living? _____ yes _____ no

Are the parents _____ married _____ divorced _____ separated _____ never married?

Who is the legal guardian? _____

If the parents are not living together, what are the custody/visiting arrangements? _____

2nd Home Address (if applicable) _____ Phone _____

Primary Parent/Guardian's Name _____

Relationship to the child _____

Employer Name and Address _____

Occupation _____ Work Phone _____

E-mail _____ Cell Phone _____

Parent/Guardian's Name _____

Relationship to the child _____

Employer Name and Address _____

Occupation _____ Work Phone _____

E-mail _____ Cell Phone _____

Besides the child, who else lives in the household?

<u>Name</u>	<u>Age</u>	<u>Relationship to the child</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are there any unusual circumstances in the family situation which you believe might influence your child's behavior? If yes, please explain: _____

What languages does your child understand and speak? _____

What languages do the parents speak in the home? _____

Health Information

Current pediatrician's name _____ Phone Number _____
Address _____ City _____ State _____ Zip Code _____

Medication

Is the child on medicine for a long-term condition (illness, allergy, etc.)? _____
If yes, please complete a Student Health History & Emergency Care Plan. These forms can be obtained at the preschool front office.

What is the medication's name and purpose? _____

If the child does not receive the medication, what reactions or changes in behavior might be seen? _____

Procedure to follow if this reaction is seen: _____

Has the child had serious injuries? _____ If yes, please explain _____

How old was the child when it occurred? _____ Has your child ever been hospitalized? _____

<u>Diagnosis</u>	<u>Age</u>	<u>Length of stay</u>	<u>Hospital</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Check if your child has or has had any of these illnesses:

- Allergy Asthma Bronchitis Chicken Pox Convulsions
- Croup Diarrhea Fainting Hepatitis Hernia
- Frequent Vomiting Food Sensitive Measles
- Rickets Nosebleeds Muscle Weakness Heart Defect
- Meningitis Mumps Tonsillitis Headaches Hives
- Pneumonia Underweight Overweight Kidney Infection
- Eczema skin rash Severe stomachache

Other _____

Has the child seen a(n):

Ophthalmologist/Optometrlist? Y/N _____ age _____ result
Audiologist? Y/N _____ age _____ result
Speech Therapist? Y/N _____ age _____ result
Psychologist/Counselor? Y/N _____ age _____ result
Dentist? Y/N _____ age _____ result
Current Dentist Name _____ **Phone Number** _____

Social/Emotional/Developmental History

Is your child adopted? _____ If so, at what age? _____ Place of birth _____

What are your child's favorite activities? _____

What are your child's favorite toys? _____

Does your child have any difficulties in speaking? _____ yes _____ no

Does your child fall easily? _____ yes _____ no

Does your child dress themselves? _____ yes _____ no

At this time, what part of dressing can your child complete alone? _____

In general, how does your child react to anxiety, or a stressful situation? Does the child cry, withdraw, throw tantrums, etc? _____

Which, if any, of the following are concerns of the parent(s)? Circle all that apply.

<i>Thumb-sucking</i>	<i>whining & crying</i>	<i>overactivity</i>
<i>Aggressiveness</i>	<i>day-dreaming</i>	<i>temper tantrums</i>
<i>Speech problems</i>	<i>quietness</i>	<i>shyness</i>
<i>Over-dependence</i>	<i>talkativeness</i>	<i>destructiveness</i>
<i>Over-independence</i>	<i>undue demand for attention</i>	
<i>Other?</i> _____		

Have any exceptionally good or unfortunate things happened to your child? _____

Do you foresee any major events coming this year in your child's life? _____

What are your child's favorite foods? _____

What foods are refused? _____

What family practices do you have about how much your child is to eat? _____

What family practices do you have about when and what kinds of snacks are available? _____

Does your child have any particular eating problems? _____

Does your child have any particular fears, such as dogs, sirens, or thunder/lightning? _____

Does your child have nightmares? _____ If yes, please describe. _____

What time does your child usually go to bed? _____

Does your child take naps at home? _____ from _____ to _____

Does your child have a special nap routine or special toy, blanket, etc? _____yes _____ no

Describe _____

What do you do to help your child go back to sleep? _____

What word is used for urination with your child? _____ bowel movement? _____

If a male child, does he prefer to sit or stand to urinate? _____

Are there any irregularities or problems connected with elimination? _____ If yes, please explain. _____

What practices does your family have about the clean-up and storage of child's toys? _____

Does your child have any other specific responsibilities around the house? _____

What do you expect your child to gain from this school experience? _____

Is there any information not specifically asked on this form that you feel the child's teacher should know about? If so please explain. _____

Religious Affiliation

Are you a member of Our Lady of the Presentation Parish? _____ yes _____ no

If Catholic, what parish do you belong? _____

Is your family non-catholic? _____ yes _____ no

Vehicle Identification

Name of those people whose vehicles will be used during pick up:

Car #1

Make _____ Model _____ Year _____ Color _____ License Plate # _____

Car #2

Make _____ Model _____ Year _____ Color _____ License Plate # _____

Thank you for your cooperation in completing this form.

Parent/Guardian Signature

Date