

Date \_\_\_\_\_ Parent or Guardian's signature \_\_\_\_\_

## GETTING ACQUAINTED

Please help us get acquainted with your child by answering the following questions. All **responses** will be **shared only with** your child's **classroom teachers** and will be treated confidentially.

Please feel free to add any information or make any comments you wish.

**CHILD'S NAME** \_\_\_\_\_ **DATE OF BIRTH** \_\_\_\_\_

Name and ages of brothers and sisters:

\_\_\_\_\_

Name and ages of other children living in the household:

\_\_\_\_\_

List all adults living in your child's home:

\_\_\_\_\_

What does your child call their grandparents (ie., grandma; grandpa; nana; papa, etc.)?

\_\_\_\_\_

The main language spoken in the household is \_\_\_\_\_

Child speaks English clearly:

- occasionally
- sometimes
- mostly

Child understands English:

- occasionally
- sometimes
- mostly

**As a condition of registration, your child must wear underwear.  
Independence from diapers or pull-ups is expected.**

Each child will be expected to dress and undress independently as well as be encouraged to wipe after completing bodily functions.

What does your child say when he/she has to use the toilet?

\_\_\_\_\_

Does your child take a nap?  yes  no

What is your child's normal bedtime? \_\_\_\_\_

Are there particular instructions for the staff that pertain to sleeping, toileting, or eating?

yes  no If yes, explain \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

About how much waking time during the day does your child spend:

Playing alone? \_\_\_\_\_ Playing with other children? \_\_\_\_\_ Watching television? \_\_\_\_\_

What opportunities has your child had to play with children other than your extended family?  
(eg: Library story hour, Playgroup..)\_\_\_\_\_

Does your child seem more at ease with adults or children?\_\_\_\_\_

Does your child like to pretend play? If so, in what way?\_\_\_\_\_

What play materials seem to hold your child's attention the longest?  
\_\_\_\_\_  
\_\_\_\_\_

What subjects does your child ask questions about?  
\_\_\_\_\_  
\_\_\_\_\_

How does your child respond to a stressful situation: (eg: thumb sucking, nervous chatter, whining, shyness...)\_\_\_\_\_

Are you aware of any fears or anxieties that your child may have? If so, what are they?  
\_\_\_\_\_  
\_\_\_\_\_

Have there been accidents, deaths, or serious illnesses in your family within your child's life experiences? \_\_\_\_\_

Because of your religious or cultural background are there any celebrations or activities that you don't want your child to participate in such as birthdays, holidays, etc.?\_\_\_\_\_

Are there any customs or traditions from your culture that you would be willing to share with the class?\_\_\_\_\_

To be answered by BOTH parents, if possible:

1. Describe one or two situations in the past year where your child has done something that you thought was special.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. What incident may have occurred in the last week or month with your child that has moved you or left you intrigued?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## HEALTH FACTS ABOUT YOUR CHILD

Was this child born premature?  yes  no

Birth weight \_\_\_\_\_ lbs. \_\_\_\_\_ oz.

Were there any complications during pregnancy, labor, or delivery?  yes  no

If yes, explain \_\_\_\_\_  
\_\_\_\_\_

Did this child have any medical problems after birth?  yes  no

If yes, explain \_\_\_\_\_  
\_\_\_\_\_

Has your child's vision been tested?  yes  no

If yes, does he/she have any problems with their vision? \_\_\_\_\_  
\_\_\_\_\_

Does he/she have frequent ear infection or tubes in ears?  yes  no

If yes, has your child's hearing been tested? \_\_\_\_\_  
\_\_\_\_\_

### LIST ANY ALLERGIES, SENSITIVITIES, AND/OR REACTIONS:

**FOOD ALLERGY** \_\_\_\_\_

**FOOD SENSITIVITIES** \_\_\_\_\_

**POLLENS** \_\_\_\_\_

**TOPICAL** (soap, lotion, etc.) \_\_\_\_\_

**BEE STINGS** \_\_\_\_\_

List any medication that is administered on a regular basis to your child: (ie: asthma, allergy medication, etc.)  
\_\_\_\_\_  
\_\_\_\_\_

ANY SPECIAL HEALTH RESTRICTIONS?  yes  no

If yes, explain \_\_\_\_\_  
\_\_\_\_\_

List of any prior hospitalizations for operations, illnesses, accidents:  
\_\_\_\_\_  
\_\_\_\_\_

Indicate "DNA" if it does not apply to your child

## SPECIAL CARE PLAN

Is your child seeing a medical specialist(e.g., occupational therapist, physical therapist, speech and language)?  yes  no

If yes, what kind and why? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name of the Specialist \_\_\_\_\_

Telephone number \_\_\_\_\_

Are special materials/equipment needed for your child while they are here in the school?  
 yes  no

If yes, explain \_\_\_\_\_  
\_\_\_\_\_

Are there any accomodations which the school must provide for your child?  
 yes  no

If yes, explain \_\_\_\_\_  
\_\_\_\_\_

Are special emergency and/or medical procedures required?  yes  no

If yes, what procedures are required? \_\_\_\_\_  
\_\_\_\_\_

Additional Information or Comments

_____ _____ _____ _____ _____ _____ _____
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