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 be completely potty/toilet trained.

My child needs assistance or has difficulty with (***check all that apply***):

- ☐ Wiping
- ☐ Dressing
- ☐ Flushing toilet
- ☐ Washing hands
- ☐ Drinking
- ☐ Eating
- ☐ Taking medication
- ☐ Brushing teeth
- ☐ Taking a nap
- ☐ Other_____

Explain how:

_____

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 televison?_____

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

_____

_____

_____

_____

_____

_____

_____