BASIC INFORMATION - PLEASE PRINT

Person completing form_____ Date_____

Child's name_____Date of Birth_____

Place of Birth_____ Sex_____ Race_____

School District: _____

E-Mail Address: _____

Home Phone Number: _____Cell Phone Number: _____

FAMILY INFORMATION

Marital status of parents _____ Never Married _____ Married _____ Separated_____ Divorced

Who has legal custody of this child? _____
(Please provide a copy of the official COURT ORDER).

List all members that reside in the child's household, including parents:

NAME	AGE	RELATIONSHIP TO CHILD

What is the primary language spoken in your home? _____

Do you have cultural preferences or considerations? _____

_____

_____

Is your child permitted to participate in all school (holiday) activities? _____ Yes _____ No

If "NO", please list activities child is not permitted to participate. _____

_____

_____

_____

Does your family have any pets? _____ Yes _____ No

Please describe _____

Does your child respond to any nicknames? _____ Yes _____ No

Please describe _____

Does your child have any nicknames for family members? _____ Yes _____ No

Please describe _____

Is there any other information about your family's composition that you would like to share? _____ Yes _____ No

_____

_____

_____

CHILD INFORMATION

Has your child been in an early learning program or childcare before? _____ Yes _____ No

If yes, would you share some information with us? (Where? When? For How Long?, Etc.) _____

_____

_____

How did your child react to other children and adults? _____ NA _____

_____

_____

Are there any special problems or fears that we should know about? _____ Yes _____ No

_____

_____

Is your child toilet trained or in the process of potty training? _____Yes _____ No

Does your child use a pull-up? _____ Yes _____ No

Does your child need to be reminded to go to the toilet during waking hours? _____ Yes _____ No

TELL US ABOUT YOUR CHILD'S DAILY ROUTINE:

Morning/Wake-Up/Breakfast/ETC – _____

_____

_____

_____

Nighttime/Bedtime/Sleep Habits/Etc - _____

_____

Is there any other information you would like to share? _____ Yes _____ No

GENERAL HEALTH QUESTIONS

Any special needs OR any other physical condition we should be made aware of (medical i.e. seizures, developmental, social)? _____ Yes _____ No

If, Yes please list any specialists that your child may have seen and supply names/numbers:

Developmental Pediatrician_____

Psychiatrist_____

Ophthalmologist_____

Psychologist_____

Audiologist_____

Neurologist_____

Other(s)_____

Do any of these special needs require special care by our Teaching Staff? _____ Yes _____ No

Does your child have any allergies? _____ Yes _____ No

Food Allergies _____ Yes _____ No _____

Environmental Allergies _____ Yes _____ No _____

Allergies to Medication _____ Yes _____ No _____

How are your child's allergies treated? _____

Is your child prone to getting easily sick? _____Yes _____ No
Is there any other information about your child's health that you would like to share? _____ Yes _____ No

_____

_____

_____

HEALTH & EARLY INTERVENTION HISTORY

Are there any diagnosed disabilities? _____Yes _____ No

If YES, check all that may apply

_____ ADD _____ ADHD _____ AUTISM _____ PDD

_____ SPEECH/LANGUAGE NEEDS _____ HEARING _____ VISION

_____ TOURETTE'S SYNDROME _____ DOWN SYNDROME

_____ CEREBRAL PALSY _____ PHYSICAL DISABILITY _____ OTHER

Where/when was the diagnosis made (please provide a copy of any reports you may have).

_____

_____

_____

Has your child been involved in any SERVICE, PROGRAM OR THERAPIES?
Check any that may apply. Please give us the name(s) of any agencies.

_____ Speech Therapy _____ Hearing Therapy

_____ Vision Therapy _____ Behavior Therapy

_____ Physical Therapy _____ Occupational Therapy

_____ Music Therapy _____ Other (please explain) _____

Are you involved with any other agencies? _____Yes _____ No

If "YES," please give us the name of the agencies and the contact persons.

_____

_____

_____

Does your child attend any other program? _____Yes _____ No

_____ Library _____ Play Group

_____ Sunday School _____ Swim Program

_____ Day Care _____ Other

HEARING

Do you have any concerns about your child's hearing? _____Yes _____ No

Is there a history of ear infections? _____Yes _____ No

If yes, when was the last one? _____

Has your child ever had tubes in his/her ears? _____Yes _____ No

Does your child talk in a loud voice? _____Yes _____ No

Does your child hear you if his/her back is turned? _____Yes _____ No

VISION

Do you have any concerns about your child's vision? _____Yes _____ No

If "YES," please explain _____

Does your child wear glasses? _____Yes _____ No

Has your child had a vision evaluation? _____Yes _____ No

If yes, when was his/her vision last evaluated? _____

COMMUNICATION

How does your child communicate with others? Check all that may apply.

_____ Pointing, gesturing _____ Single words _____ 2,3,4-word phrases

_____ Sentences _____ Signing

Can family members understand your child's speech? _____Yes _____ No

Can people outside your family understand you child's speech? _____Yes _____ No

ACTIVITY/FOOD PREFERENCES

List your child's favorite activities and materials: _____

_____

_____

List your child's least favorite activities (messy activities, etc.)? _____

_____

_____

Does he/she eat independently? _____Yes _____ No

What are your child's favorite foods/snacks?_____

_____

_____

MOTOR DEVELOPMENT

Do you have any concerns regarding your child's motor development (how he/she uses his/her large muscles for running, jumping, ball skills)? _____Yes _____ No

If "YES," please explain _____

_____

_____

If your child has a diagnosed physical disability, does he/she use any special equipment at home?

_____Yes _____ No at school? _____Yes _____ No on transportation? _____Yes _____ No

If yes to any, please explain _____

_____

_____

SOCIAL DEVELOPMENT

Do you have concerns about your child's social development? (how he/she interacts with other children, how he/she focuses during play.) If "YES" please explain: _____

_____

_____

Does your child have any fears? (loud noises, etc.) _____

_____

_____

THANK YOU.
TEACHERS & THERAPISTS at WVCA