

EARLY CHILDHOOD EDUCATION

Child Information Form

Child's First Name	Child's Last Name	
Date of Birth (Mo/Day/Yr)	<input type="checkbox"/> Male <input type="checkbox"/> Female	
Address		
City	State	Zip Code
Primary Phone		

Mother's Name	
Email Address	Occupation
Father's Name	
Email Address	Occupation

Special talent, skill or hobby that you are able to share with the class, staff or Center:

Brothers & Sisters		
Name	DOB	School

Are there others living in the household? Yes No
If yes, relationship to child:

Language(s) other than English spoken in home? Yes No
If yes, which languages?

Does your child have any allergies? Yes No
If yes, please describe and list any airborne allergies your child has:

Is this your child's first nursery school experience? Yes No
If not, list camps or schools:

Is your child toilet trained? Yes No
 Does your child need to be reminded to use the toilet? Yes No

Has your child had any formal testing? Yes No
If yes, what type of testing?

What type of play does your child prefer?

(Please check as many behaviors as apply.)

- | | | |
|--|---|---------------------------------|
| <input type="checkbox"/> ACTIVE | <input type="checkbox"/> IMAGINATIVE PLAY | <input type="checkbox"/> MUSIC |
| <input type="checkbox"/> INDOOR | <input type="checkbox"/> QUIET | <input type="checkbox"/> TRUCKS |
| <input type="checkbox"/> ALONE | <input type="checkbox"/> OUTDOORS | <input type="checkbox"/> BLOCKS |
| <input type="checkbox"/> WITH AN ADULT | <input type="checkbox"/> WITH A PEER | <input type="checkbox"/> OTHER: |
| <input type="checkbox"/> CRAFTS | <input type="checkbox"/> DOLLS | |
| <input type="checkbox"/> MANIPULATIVE | <input type="checkbox"/> DRESS-UP | |

Which behaviors best describe your child when upset?

(Please check as many behaviors as apply.)

- | | |
|--|---|
| <input type="checkbox"/> CRIES EASILY | <input type="checkbox"/> VERBALLY ABUSIVE |
| <input type="checkbox"/> HAS TEMPER TANTRUMS | <input type="checkbox"/> WITHDRAWS |
| <input type="checkbox"/> BITES | <input type="checkbox"/> REGAINS COMPOSURE EASILY |
| <input type="checkbox"/> HITS | <input type="checkbox"/> OTHER: |
| <input type="checkbox"/> KICKS | |

What situations might cause your child to become upset?

(Please check as many behaviors as apply.)

- | | |
|--|--|
| <input type="checkbox"/> SHARING | <input type="checkbox"/> SEPARATION ISSUES |
| <input type="checkbox"/> FOOD ISSUES | <input type="checkbox"/> THUNDER |
| <input type="checkbox"/> LIMIT SETTING | <input type="checkbox"/> TOILET |
| <input type="checkbox"/> BEING TOUCHED | <input type="checkbox"/> DARKNESS |
| <input type="checkbox"/> LIGHTNING | <input type="checkbox"/> OTHER: |
| <input type="checkbox"/> LOUD NOISES | |

Does your child have any special needs or learning issues that you are aware of?

What method of discipline is used in your home?

What is your child's reaction to this discipline?

Is there anything else that you would like us to know about your child that would help us to better understand her or him?
