HOPE Preschool

Child/Family Personal History

The purpose of collecting this information about your child is to help the HOPE Preschool staff better understand your child and thus support and encourage their success in preschool. All information is kept confidential and requires your written permission before being shared. Some questions may not be applicable to your child at this time; please leave them blank.

FAMILY INFORMATION Date _____

Child's Name _____ Known as _____

(Name you wish your child to write and identify)

Sex _____ Age _____ Date of Birth _____

Address _____

_____

How long have you lived in this city? _____

Mother (guardian) _____ Occupation _____

Employer name & address _____

Father (guardian) _____ Occupation _____

Employer name & address: _____

Marital Status: Married _____ Divorced _____ How long? _____

Single Parent _____ Separated _____

Custody/visiting arrangements _____

Siblings: Name _____ Date of Birth _____

Name _____ Date of Birth _____

Name _____ Date of Birth _____

Other members of the household (include relationship and age) _____

_____

Is English your child's primary language? _____

Do you speak a language at home other than English? _____ If so, what? _____

Are there special words that would help us communicate with your child? _____

_____

Are there any cultural practices or holidays you would like us to know about? _____

_____

What age was your child when he/she first separated from Mom and/or Dad? (i.e. illness, hospitalization, babysitter, school, daycare, etc.) _____

What daycare/preschool did your child attend before:_____

DEVELOPMENTAL MILESTONES

Age your child began sitting _____ crawling _____ walking _____

Is your child a good climber? _____ Does he/she fall easily? _____

Age your child began talking _____Does your child speak in words? _____ or sentences? _____

Does your child have any speech delays or challenges? _____

SLEEPING HABITS

What time does your child go to bed? _____ Awaken? _____

Does he/she have his/her own room? _____ Own bed? _____

What item does your child take to bed with him/her? _____

Does your child take naps? ____ what time/how long?_____

SOCIAL AND EMOTIONAL DEVELOPMENT

Has your child had experience playing with other children? _____

By nature, is your child: Friendly _____ Aggressive _____ Shy _____ Withdrawn _____

How does your child get along with his/her brothers and sisters? _____

Other adults? _____

With what age child does he/she prefer to play? _____

Will your child know any children in the preschool? _____

What makes your child angry or upset? _____

_____

How does your child show his/her feelings? _____

_____

What discipline method(s) is used in your home? _____

_____

What is your child's usual reaction to discipline? _____

_____

Who does most of the disciplining? _____

Is your child frightened by any of the following: Animals _____ Tall people _____ Loud noises _____

Dark _____ Storms _____ Anything else? _____

Does your child have a pet? _____ Type _____ Name _____

How much time does your child spend using electronics each day?

TV _____ Computer_____ Video Games _____ IPad_____ Cell Phone _____

What are your child's favorite programs, games, etc.? _____

_____

Favorite toys and activities at home _____

_____

Does your child like to read or be read to? _____ Visit the library? _____ Listen to music? _____

Does your child enjoy playing outdoors? _____ Ride a tricycle or scooter? _____

Has your child had experience with: Play Dough _____ Scissors _____ Easel painting _____

Crayons/Markers_____ Finger painting _____ Blocks _____ Water play _____

What do you consider to be your child's strengths? _____

_____

What do you and your child enjoy doing together? _____

_____

Does your child have any difficulties that we should be aware of? _____

_____

HEALTH HISTORY

Does your child have any chronic illnesses or medical conditions we should be aware of?

_____

Does your child have frequent: Colds _____ Earaches _____ Stomachaches _____ Nosebleeds_____

Explain_____

Does your child vomit easily? ____ Explain _____

Does your child experience high fevers often? _____ Explain _____

Has your child had any serious injuries? _____ Explain _____

Does your child have *non-food* allergies? ____ Symptoms?_____

Does your child have any food allergies? _____ List Foods _____

Symptoms _____

Does your child have a doctor-prescribed EpiPen Jr. or AuviQ ? _____

Has your child ever been hospitalized? _____ Explain _____

Has your child ever had a vision test? _____ a hearing test? _____

Does your child wear corrective shoes? _____ Glasses?_____

Does your child have any special accommodations? _____

Does your child eat with a spoon? ____ Fork? _____ What time does your child eat breakfast? _____

Is your child right or left-handed? _____ Is your family vegetarian? _____

Other dietary restrictions: _____

TOILET HABITS

(Please remember, due to our licensing requirements, your child must be able to independently use the bathroom.)

Can your child be relied upon to let the teacher know they need to use the bathroom? _____

What word is used for urination? _____ for bowel movement? _____

Does your child need to go more frequently than usual for his/her age? _____

Is your child frightened of the bathroom? (for example, flushing toilet?_____

Does your child have accidents? _____ How does he/she react to them? _____

Does your child need help with toileting (i.e. help with clothing, zippers, buttons)? _____

Was your child easy or difficult to toilet train? _____

Does he/she wet the bed at night? _____ How often? _____

OTHER

Briefly describe your child (personality, abilities, etc.) _____

_____

_____

_____

_____

_____

What are your expectations for your child at HOPE Preschool? In what particular ways can we help your child? _____

_____

_____

_____

_____