Pembroke Public Schools

North Pembroke Elementary School
72 Pilgrim Road, Pembroke, MA 02359

781-826-5115
339-244-5036

INTEGRATED PRESCHOOL PEER APPLICATION
2024-2025 School Year

Date_____

Child's Last Name: _____First:_____Middle:_____

Home Address_____

_____
Town State ZIP

Age on September 1, 2024_____ Date of Birth_____ Sex M F
(child must be 3 by September 1, 2024)

(Please choose one, checking more than one option will void your application)

_____I am interested in the four-day (half-day) program M-Th 8:15-11:00 AM/ 12:00-2:45 PM

_____I am interested in the five day (full-day) program M-F 8:15 AM-2:45 PM

Parent/Caregiver #1

Name: _____
Address: _____
Phone: _____
Email:_____

Parent/Caregiver #2

Name: _____
Address: _____
Phone: _____
Email: _____

Has your child been identified as having special needs? _____yes _____no

All children must participate in a child find screening for this program. You will be contacted to schedule an appointment for your child after returning this application.

Parent Questionnaire Form

Dear Parent:

Please answer the questions on this form in the best way that you can.

Your answers on this form will help the preschool staff decide what kind of educational program is best suited for your child.

This questionnaire is confidential and your responses are shared only with professional personnel.

Child's Name_____ Today's Date_____

Street Address_____

Sex M F Date of Birth_____ Birthplace_____

Telephone Number: Home_____ Cell_____

Name of Person (s) Filling Out Form_____ Relationship to Child_____

Caregiver email address:_____

1. Child's School History

Has your child attended school before? _____yes _____no

If yes, name of school_____

Dates of attendance (month/year)_____ to _____

Number of days per week: _____2 _____3 _____4 _____5 ___FT ___PT

Any other school experience? _____

2. Child's Status in Family

_____oldest _____middle _____youngest _____only

Other children in family:
_____ age_____ school _____
_____ age_____ school _____
_____ age_____ school _____

Do any of your children experience difficulty in school?

Name	School	Area of Difficulty
_____	_____	_____
_____	_____	_____

Has any family member or close relative had significant difficulty in school?

If yes, Relationship_____ Nature of Difficulty_____

3. Parents

Caregiver #1 Name_____ Occupation_____

Place of Work_____ Phone_____

Parent email_____

Caregiver #2 Name_____ Occupation_____

Place of Work_____ Phone_____

Parent email_____

Primary Language spoken in the home: _____

Other persons residing in the household:

Names_____

Relationship(s) _____

Have there been any extraordinary events in this household? (illness, moves, death, disaster, change in make-up of family)

_____

_____

Any serious caregiver or family health problems? _____

4. Basic Medical Data

Name of Child's Doctor_____ Telephone_____

Address_____

Has your child ever had any ear/hearing examination or treatment?

_____yes _____no If so, when? _____

Doctor_____ Results_____

Ear infections? _____yes _____no If yes, _____Infrequent (2-3 times per year)

_ _____Frequent (4 or more per year)

_

_____Prolonged (10 days - 2 weeks)

Dates of ear infections_____

Do you suspect any hearing problems? _____yes _____no

Does your child:

Seem to have difficulty hearing?	Yes	No
Turn up the TV louder than other members of the family?	Yes	No
Seem to favor one ear over the other?	Yes	No
Jump or appear to be more startled than others if there is a sudden noise?	Yes	No
Seem to hear you if you talk in a whisper?	Yes	No
Make you talk loudly or repeat frequently?	Yes	No

Has your child ever had a vision examination or treatment? _____yes _____no

If so, when? _____ Doctor _____

Results_____

Do you suspect any vision problems? _____yes _____no

Does your child:

Seem to have difficulty seeing small lines or pictures?	Yes	No
Seem to have a problem seeing things far away?	Yes	No
Squint?	Yes	No
Wear glasses?	Yes	No
Have eyes that turn in?	Yes	No
Have eyes that turn out?	Yes	No

Sit very close to the television?	Yes	No
Rub eyes frequently?	Yes	No

What is the approximate age that your child spoke: _____

First Words _____ 2 or 3 words together_____ Sentences_____

At what age did your child first begin to walk?
Give approximate age if you do not remember exact age: _____

Do you feel your child has adequate large muscle coordination? _____yes _____no

Do you notice, or has your doctor reported, any of the following in your child?

	Asthma		Heart Trouble		Frequent Fevers
	Sleep Disorder		Medical Problems Immediately after birth		Epilepsy (seizures)
	Diarrhea		Chronic Ear Infections		Chronic Stomach Problems
	Vomiting		Diabetes		Hyperactivity
	Headaches		Allergies (type)		Food Allergies (specify)
	Sinus Trouble				

Comments: _____

_____

Please check *Yes*, *Sometimes*, *No*, or *Not Sure* for each of the following statements:

It is my (our) opinion that our child:

	Yes	Sometimes	No	Not Sure
Has regular playmates the same age				
Has difficulty getting along with other children				
Has difficulty expressing self				
Prefers to play with other children instead of alone				
Is difficult to understand when talking				
Seems generally happy				
Is frequently irritable or moody				
Is upset by changes in routine				
Demands much individual adult attention				

Accepts discipline and limits				
Becomes confused in following more than two verbal directions at a time				
Has difficulty remembering things for a short time				
Has difficulty remembering things for a long time				
Is easily frustrated				
Cries easily				
Cooperates willingly				
Has a bad temper				
Can use a fork and spoon without help				
Can catch a ball thrown to him				
Enjoys physical activities				
Loses balance, trips, and falls				
Has difficulty running				
Is dealing with a family stress such as illness, death, or separation				

How old are your child's favorite playmates? _____

About how many hours a day does your child watch TV? _____ Screen time: _____

What kinds of things do you like to do with your child? _____

_____

Do you have any special concerns about your child? _____

_____

Is your child toilet trained? _____

Is there any other information that will help us better understand your child?

_____

Other physical problems or serious illnesses (explain) _____

_____

Child's Birth Weight _____lbs. _____oz.

Special Considerations

_____Caesarean _____Premature

_____Cord around neck _____Breech _____Multiple~1st born, 2nd born, 3rd born

_____Baby blue _____Jaundice _____IVF

Special Care

_____Oxygen (how long) _____

_____Incubator (how long) _____

_____Hospital stay (how long) _____

_____Seizures or loss of consciousness? _____

Is your child presently on medication? _____ What? _____

Has your child had any significant injuries or hospitalization? _____

_____

Has your child had Special Education needs in the past or currently?

_____

Do you participate in any of the following programs? (*Please check*)

_____Social Security _____Medicaid _____Welfare

_____Food Stamps _____WIC

Thank you for your cooperation in filling out this questionnaire.

I also give permission to preschool staff to take a photograph of my child, to remain in their file throughout the preschool admission process.

Name _____

Date_____

Please return this completed application to the main office at North Pembroke Elementary School by 2:00PM on Friday, February 16, 2024.