



Carlisle Public Schools

83 School Street Carlisle, MA 01741 Phone: 978-369-6550 Fax: 978-371-2400

CARLISLE INTEGRATED PRESCHOOL APPLICATION FORM

Application Date: ___/___/___

Child's Name: _____

Date of Birth: ___/___/___

Address: _____

Age: _____

Sex: Male Female

Primary Language: _____

Second Language: _____

Check one:

Interested in 5 full days (8:45-2:45)

Interested in 5 half days (8:45-12:15)

Parent/Guardian Information

Name: _____

Biological Parent Adoptive Parent Guardian

Sex: Male Female

Address: _____

Phone Number: _____

Email Address: _____

Occupation: _____

Work Place: _____

Work Phone: _____

Name: _____

Biological Parent Adoptive Parent Guardian

Sex: Male Female

Address: _____

Phone Number: _____

Email Address: _____

Occupation: _____

Work Place: _____

Work Phone: _____

Sibling Information			
Name	Sex	Age	Grade Level / School
	<input type="checkbox"/> Male <input type="checkbox"/> Female		
	<input type="checkbox"/> Male <input type="checkbox"/> Female		
	<input type="checkbox"/> Male <input type="checkbox"/> Female		
	<input type="checkbox"/> Male <input type="checkbox"/> Female		

Please list any additional members of the household.			
Name	Sex	Age	Relation
	<input type="checkbox"/> Male <input type="checkbox"/> Female		
	<input type="checkbox"/> Male <input type="checkbox"/> Female		
	<input type="checkbox"/> Male <input type="checkbox"/> Female		

Please list 3 emergency contacts for your child.			
Name	Sex	Relation	Phone Number
	<input type="checkbox"/> Male <input type="checkbox"/> Female		
	<input type="checkbox"/> Male <input type="checkbox"/> Female		
	<input type="checkbox"/> Male <input type="checkbox"/> Female		

Please list information for your child's pediatrician and dentist.	
Pediatrician's Name: _____	
Address: _____	Phone Number: _____
Dentist's Name: _____	
Address: _____	Phone Number: _____

Please list all prior daycare/childcare/preschool experiences:

School or Center:_____ Address:_____

Dates Attended:_____ Phone Number:_____

School or Center:_____ Address:_____

Dates Attended:_____ Phone Number:_____

School or Center:_____ Address:_____

Dates Attended:_____ Phone Number:_____

Please share with us how you first learned about the Carlisle Integrated Preschool, and why you are interested in applying for entrance at our school.

What would you like your child to gain from their preschool experience?

Developmental History

Was this child adopted or born via surrogate? Yes No

If yes, please describe the circumstances and any important details:

Weeks Gestation: ____ weeks

Birth Weight: ____ pounds, ____ ounces

Birth Length: ____ inches

Were there any difficulties during pregnancy, birth, or shortly thereafter? Yes No if yes, please explain:

Has your child had any hospitalizations, serious illnesses, or accidents? Yes No if yes, please explain:

Are there any current medical concerns for your child, including allergies? Yes No if yes, please explain:

Has your child had frequent ear infections? Yes No if yes, please explain:

Has your child had any hearing difficulties? Yes No if yes, please explain:

Has your child had any vision difficulties? Yes No

if yes, please explain:

Please describe your child's current toilet training status.

Do you have any concerns for your child's development? Yes No

if yes, please explain:

Please indicate the age at which your child demonstrated the following milestones.

Turn Over: _____

Smile: _____

Crawl: _____

Babble: _____

Walk: _____

Speak First Word: _____

Walk Up Stairs Unassisted: _____

Speak 2-word Phrase: _____

Walk Down Stairs Unassisted: _____

Speak Short Sentence: _____

Run Smoothly: _____

Follow One-Step Direction: _____

Jump with Both Feet: _____

Follow Two-Step Direction: _____

Kick Large Ball: _____

Catch Large Ball: _____

Was your child evaluated for Early Intervention services?

Yes No

Did your child qualify for Early Intervention services?

Yes No

Which services did your child receive?

Occupational Therapy

Speech and Language Therapy

Physical Therapy

Vision Therapy

Feeding Therapy

Other: _____

Please describe your child's speech articulation:

hard to understand

only familiar adults can understand

easy to understand

If you have concerns for your child's speech articulation, please describe below:

Please describe your child's interests and preferred activities.

Please describe your child's social skill development.

Please describe the method of behavior management at home.

