

PRESCHOOL REGISTRATION INFORMATION

Today's Date: _____

Child's Name: _____

Date of Birth: _____

SECTION I:

When you were pregnant with your child, were there any complications? Yes _____ No _____

If 'yes' please explain: _____

After delivery, was the baby in the hospital longer than two (2) days? _____

If yes, please explain: _____

At what age did your child begin to: walk? _____ talk? _____

Does your child have any of the following habits:

Toilet accidents? _____ Temper tantrums? _____ High activity level? _____

Difficulty separating from you? _____ Excessive crying? _____

Has your child experienced any of the following difficulties, past or present?

Speech _____ Hearing _____ Eating _____ Sleeping _____

Does your child have any Physical Restrictions? _____ Allergies: _____

If 'Yes' to either, please explain: _____

What are your child's strengths? _____

What are your child's challenges? _____

Is there anything you find difficult about parenting? _____

Is there anything else you would like us to know about your child? _____

Does your child have any relatives enrolled in the Preschool Program? _____

Please list names and relationship:

Has your child attended another Preschool? _____ If 'Yes' please provide the following:

Name: _____

Address: _____ Phone: _____

City: _____ State: _____

Has your child ever received services from Early Intervention? Yes _____ No _____

If 'Yes' When _____ Where _____

If 'Yes' When _____ Where _____
Where did you hear about our preschool program? _____

SECTION II

Written Consent pursuant to 20 U.S.C 1232g (b) (1) 34 C.F.R 99.30 (b).

HEALTH HISTORY INFORMATION

Please answer all questions to the best of your knowledge. ALL information will be kept confidential.

Child's Name: _____ Gender: _____
D.O.B: _____ Age now: _____
Address: _____
Home Phone: _____ Cell Phone: _____
Father: _____ Age: _____ Mother: _____ Age: _____
Child's Place of Birth: _____ Hospital: _____

Family History:

A. List any persons (other than siblings) residing in the home and their relationship to the child:

1. _____
 2. _____ 3. _____
- _____

B. Any instances of serious illnesses among *immediate family members*: Such as:

____ Epilepsy ____ Alcoholism ____ T.B. ____ Diabetes ____ Asthma ____ Other:

SECTION III

PREGNANCY

A. Any problems during pregnancy? YES NO

- a. Illness _____
- b. Infection _____
- c. Convulsions _____
- d. Bleeding _____
- e. Emotional Problems/stress _____
- f. Medications _____
- g. Other _____

If you answered "yes" to any of the above, please explain : _____

B. Did mother smoke during pregnancy? _____

C. Does anyone in the home smoke? _____

- B. Did mother smoke during pregnancy? _____
- C. Does anyone in the home smoke? _____
- D. Was pregnancy full term _____ or premature _____ (how many weeks early) _____
- E. Was the delivery a normal spontaneous one? _____
- If not a normal, spontaneous delivery, please explain below what type of delivery and reason:
(Ex. forceps, cesarean, etc.)

SECTION IV

CHILDBIRTH HISTORY

- A. Birth weight _____
- B. Any problems after birth (ex difficulty breathing, convulsions, weight loss, incubator, etc)? _____
- a. If 'Yes', please explain: _____
- _____

Developmental History/Milestones

- A. Please indicate as closely as possible in months and years:

- a. Held head erect while lying on stomach _____
- b. Follow objects _____
- c. Sat independently _____
- d. Stood alone _____
- e. Walked alone _____
- f. Talked (babbled), imitate sounds _____
- g. Talked (in words/sentences) _____
- h. Bladder trained _____
- i. Bowel trained _____
- j. Fed self _____
- k. Right or Left handed _____

- B. Any head injuries, illnesses, asthma, hay fever, allergies, frequent ear infections, fractures, convulsions, etc.
Yes _____ No _____ If 'yes' please explain:

- C. Any hearing, vision, speech, or orthopedic issues: Yes _____ No _____ If 'yes' please explain:

- D. Is your child taking medication? Yes _____ No _____ If 'yes' please explain:

Medication: _____ Condition: _____ Medication: _____
Condition: _____

- E. Is your child allergic to any food or drug? Yes _____ No _____ If 'yes' explain:

- F. Describe your child's eating habits:

G. Describe your child's Social Skills:

YES

NO

- 1. Shy
- 2. Outgoing (friendly)
- 3. Happy
- 4. Talkative
- 5. Confident
- 6. Fearful
- 7. Temper Tantrums
- 8. Easily Angered
- 9. Moody
- 10. Quiet
- 11. Aggressive
- 12. Withdrawn

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

If you wish to explain your child's social skills further:

Parent Signature

Date