

St. Clement Preschool Questionnaire

Identification

Child's Name _____ Nickname _____
Address _____ City _____ State _____ Zip _____
Age _____ Birthdate _____ Place of Birth _____
Social Security # _____ Baptism (date & place) _____

Information below is classified confidential

Family Information:

Mother (or guardian) _____ Marital status _____
Father (or guardian) _____ Marital status _____

Other children in the family:

Name _____	age _____	School _____	grade _____
Name _____	age _____	School _____	grade _____
Name _____	age _____	School _____	grade _____
Name _____	age _____	School _____	grade _____

Other individuals who reside in the home:

Name _____ Relationship to child _____
Name _____ Relationship to child _____
Name _____ Relationship to child _____

Maternal Grandparents names _____

Paternal Grandparents names _____

Pets (kind and name) _____

Babysitter information:

Name _____ Phone _____
Address _____ City _____ Zip _____
Times child is with sitter _____

Comments: (any other pertinent information to above information that you feel we should be aware of) _____

Questionnaire continued:

Personal Data:

Developmental History:

Age at which child: Crept on hands and knees _____ sat alone _____

Stood alone _____ walked _____ slept through the night _____

Named simple objects _____ terminology used for lavatory _____

Toilet trained _____ repeated short sentences _____

Does your child dress self? _____ undress self? _____

Is child right or left handed? _____

When does child usually go to bed? PM _____ Awaken _____ Am Nap _____

Health History:

Does your child have any physical problems that the school should be aware of (food allergies, vision, hearing) Yes _____ No _____

If "yes" please explain what, cause and reaction _____

Is your child prone to colds, stomach aches, etc? yes _____ no _____

Does your child take medication or school-related medication on a periodic or regular basis? Yes _____ no _____ sometimes _____

Why? _____

What kind? _____

Has your child had any serious accidents/illnesses? (explain) _____

General Information:

What are your child's favorites:

Foods: _____

Colors: _____

Types of toys: _____

Indoor play activities: _____

Outdoor play activities: _____

Places to be: _____

Habits: _____

Questionnaire continued

What does the family do together? _____

How are most evenings spent? _____

Does child have own room/shared room? (with whom) _____

Do you read to your child? yes _____ no _____
Child's preference (fairy tales, animal stories, etc.) _____

Does child ask a lot of questions/listen for response? _____

Does your child have any special fears that you are aware of? _____

Has special testing ever been recommended for your child? yes _____ no _____
if yes, please explain _____

What method of discipline is used in your home? By whom? _____

What is your child's usual reaction? _____

How would you describe your child's personality? _____

Does your child have playmates? (explain) _____

Child's group behavior usually is:
Friendly _____ fearful _____ shy _____ aggressive _____ happy _____
Has your child had any previous day-care or nursery experience? yes _____ no _____
How long? _____ Where? _____ Reactions? _____

Comments or questions you may have, _____

Thank you for your assistance

Signature

Date