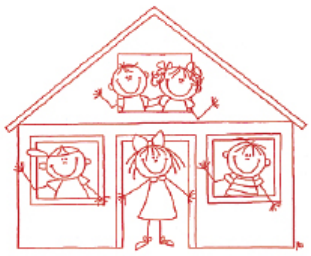

First Presbyterian Nursery School
178 Oenoke Ridge Road, New Canaan, CT 06840 (203)966-5234

Child/Family Personal History

The purpose in securing this information about your child is to help the Teachers better understand your child and to help you know what to expect from the school. Your child's care during the day is a responsibility we share. All information is kept confidential and requires your written permission if it is to be shared. Please use the back sides of form if you wish to elaborate more on a question. Some questions may not be applicable to your child at this time; please leave them blank.

Family and Social History

Telephone: _____

Name of Child: _____ Birth Date: _____

Mother (or guardian): _____ Age: _____

Father (or guardian): _____ Age: _____

Marital Status of Parents:

Married_____ Divorced_____ Separated_____ Single Parent_____

(How Long?) (How Long?)

Remarks:_____

_____

Custody/visiting arrangements: _____

Siblings:

Name: _____ Birth Date: _____

Name: _____ Birth Date: _____

Name: _____ Birth Date: _____

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

_____

_____

_____

How long have you lived in this city? _____

Do you speak a language at home other than English? _____

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

_____

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

_____

Personal History

Type of Birth: _____Full Term _____Premature

Any complications? _____

Age he/she began sitting _____crawling _____walking _____

Is he/she a good climber? _____Does he/she fall easily? _____

Age he/she began talking _____Does he/she speak in words _____or sentences? _____

Does he/she have any speech problems? _____

Other language _____

Special words to describe his/her needs _____

Sleeping

What time does child go to bed? _____Awaken? _____

Is he/she ready for sleep? _____Does he/she have his own room? _____

Own bed? _____Does he/she walk, talk or cry out at night? _____

What does he/she take to bed with him/her? _____

What is his/her mood on awakening? _____

Does he/she take naps? (From when to when?) _____

Social Relationships

Has he/she had experiences in playing with other children? _____

By nature is he/she Friendly? _____Aggressive? _____Shy? _____Or withdrawn? _____

How does he get along with his brothers and sisters? _____

Other adults? _____

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

Will he/she know any children in the center? _____

Do you feel he/she will adjust easily to the childcare situation? _____

What makes him/her angry or upset? _____

How does your child show his/her feelings? _____

What method of behavior control is used in your home? _____

What is child's usual reaction? _____

Who does most of the disciplining? _____

Is he/she frightened by any of the following? Animals? _____Tall people? _____Rough children? _____Loud noises? _____Dark? _____Storms? _____Anything else? _____

_____

Favorite toys and activities at home _____

Does he/she like to be read to? _____Listen to music? _____

Does he/she prefer to play outdoors? _____Can you child ride a tricycle? _____

Has he/she had experience with: Clay? _____Scissors? _____Easel painting? _____

Finger painting? _____Blocks? _____Water play? _____

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

_____

Health History of Child

What past illnesses has he/she had? What age?

Chicken pox	_____	Scarlet Fever	_____
Diabetes	_____	Malaria	_____
HIV	_____	AIDS	_____
Measles	_____	Hepatitis A	_____
Hepatitis B	_____	Mumps	_____

Other: _____

Does your child have frequent colds?_____

Explain: _____

Tonsillitis? _____Ear Aches? _____Stomach Aches? _____

Does he/she vomit easily?_____

Does he/she run high fevers easily?_____

Has your child had any serious accidents? _____Explain: _____

_____

Is child allergic? _____If so, how does it usually manifest itself? Asthma? _____

Hay Fever? _____ Hives? _____ Other? _____ Do you know what his/her allergy is caused by? _____

Has your child ever been hospitalized? _____What for? _____

Has your child ever been to a Dentist? _____Has he had his vision tested? _____

Hearing tested? _____ Does he wear corrective shoes? _____

Does your child have any handicaps? _____ Describe: _____

Please give a statement of you evaluation of your child's overall health:_____

_____

Eating

Is child usually hungry at mealtime? _____Between meals? _____

What are his/her favorite foods? _____

What foods are refused? _____

What eating problems does the child have? _____

Any food allergies? _____

Does child eat with a spoon? _____Fork? _____Hands? _____

Is child left or right handed? _____What time does your child usually eat breakfast?___

Lunch? _____Dinner? _____Is family vegetarian? _____

Other dietary restrictions: _____

Toilet Habits

Can the child be relied upon to indicate his toileting wishes? _____

What word is used for urination? _____For bowel movements? _____

Does the child need to go more frequently than usual for his age? _____

Is he/she frightened of the bathroom? _____Does he/she have accidents? _____

How does he/she react to them? _____

Does child need help with toileting? _____

Was the child easy or difficult to toilet train? _____

Does the child wet his/her bed at night? _____How often? _____

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

_____

_____

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

_____

_____

_____