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 _____

Where did you hear about our preschool program? _____
Does your child need transportation to attend school? Yes _____ No _____

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*: Yes: _____ No: _____
Such as: Epilepsy ____ Alcoholism ____ T.B. ____ Diabetes ____ Asthma ____Hay Fever ____
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? _____
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