PRESCHOOL PROGRAM SELECTION FORM

Child's Name________________________________D.O.B. ___/___/__
Mo.Day Year

Age August 31, 2008_____________________________

Please select the program(s) of interest for your child for the 2008/2009 school year. Specify your first (1st) and second (2nd) choice from the programs listed. Thank you.

Program A

2 day program Tuesday/Thursday mornings, 8:30 am to 11:00 am
Age: 3 year olds

Program B

3 day program Monday/Wednesday/Friday mornings, 8:30am to 11:00 am
Age: 3-4 year olds

Program C

4 day program Monday/Tuesday/Thursday/Friday Afternoon 12 to 3:00 pm
Age: 4-5 year olds

1st Choice: ***Program____***

2nd Choice: ***Program____***

Parent/Guardian:

Signature______________________________________Date_______________

PRESCHOOL DEVELOPMENTAL HISTORY

Name:____
Last First Middle

PERSONAL HISTORY:
Type of Birth______________________________Any complications?____________________________
Age began sitting_______________Crawling_______Walking__________Talking________________
Any difficulties in speaking?____
Other languages spoken at home____
Special words to describe needs____

HEALTH:
Any serious illnesses or operations?____
Any physical disabilities or allergies (asthma, hay fever, insect bites, medicine)?____
Any medications given regularly?____

EATING HABITS:
Does your child have any eating problems?____
Food Allergies?_______________________________Food refused?_____________________________
Does your child eat with a spoon?_________________Fork?______________Hands?_______________

TOILET HABITS:
Does your child indicate his/her bathroom needs?____
Word for urination?___________________________Word for bowel movement____________________
Is your child frightened of the bathroom?__________________Does your child have accidents?____________

SLEEP HABITS:
Does your child take naps?__________Time: From_______________To_________________________
What time does your child go to bed at night?________________Awaken in morning?__________________
Mood on awakening?____
What does your child take to bed with him/her?____

SOCIAL RELATIONSHIPS:
Has your child had experience playing with other children?____
By nature, is your child friendly?_____Aggressive?___________Shy?__________Withdrawn?_________
How does your child relate to strangers?____________________Does your child play well alone?__________
What is your child's favorite toy?____
Do animals frighten your child?________Rough children?________Loud noises?________Darkness?_______
Storms?_________Anything else?____
Who does most of the disciplining at home?____
What is the best way to handle your child?____
____
How do you comfort your child?____
____
Is your child receiving any special services?________Speech?________Counseling?____________________
Physical Therapy?__________Occupational Therapy?______________Other?_______________________

Please explain____
____