



Date _____

INFORMATION SHEET

Child's Full Name _____ Nickname _____

Date of Birth _____ Gender _____ Telephone _____

Address _____

Email Address _____

Is it ok to use email to communicate school info and to include in our directory? Yes ____ No ____

FAMILY:

Parent

Parent

Name: _____

Home Address: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Pager: _____

Occupation: _____

Employer Name: _____

Work Address: _____

Work Hours: _____

Physician

Name _____ Phone _____

Address _____

Siblings

Name Date of Birth School and Grade General Health

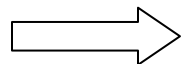
Please list anyone else who lives in your home or spends a significant amount of time with your child:

Have any of your children attended Glenview Methodist Preschool? _____ Years _____

Did you or your spouse attend Glenview Methodist Preschool? _____ Years _____

What kindergarten will your child attend? _____

How did you first hear about Glenview Methodist Preschool? _____



SOCIAL RELATIONSHIPS AND DEVELOPMENT:

Has your child had prior experience with groups (i.e. other school, church, etc.)? _____

When & where? _____

Does your child play with other children? _____

What age did your child begin walking? _____ Talking? _____

Does your child have any difficulties speaking? _____

Is a language other than English spoken in the home? _____ If yes, what language(s)? _____

Do you have a particular religious affiliation that should be considered in daily activities in the classroom? _____ Yes _____ No

Please be specific on which activities this would include. Does this involve dietary restrictions?

Is your child right or left handed? _____ Have a pet? _____

What is your child's favorite play activity? _____ Toy? _____

How often is your child read to? _____

What time does your child go to bed? _____ Awaken? _____

Characteristic Behavior: (Circle the word or words that apply)

CALM EXCITABLE EASILY ANGERED WHINING CRYING HAPPY

CHEERFUL STUBBORN COOPERATIVE QUIET INDEPENDENT

FIGHTS OFTEN GIVES IN EASILY WANTS OWN WAY ACTIVE TEMPER TANTRUMS

OTHERS: _____

How would you describe your child's personality? _____

Does your child have any fears? (Please give history and describe how the fear is shown.) _____

What makes your child frustrated or upset? _____

Does your child have any needs/handicaps requiring special attention? _____

TOILET HABITS:

Has your child learned to use the toilet? _____ If so, at what age? _____

Can your child be relied upon to indicate his/her bathroom wishes? _____

Does he/she have accidents? _____

HEALTH: (A state form will be sent at a later date for completion by you and your doctor.)

Does your child have allergies, frequent colds, etc.? (Specify) _____

Has your child had any serious illness, operations or accidents? (Specify) _____
