



Child Information

Child's Name _____ Date _____

Current Age _____ Date of birth _____ Gender _____

Mother's name _____ Home Phone _____

Address _____ Work Phone _____

City & Zip _____ Employer _____

Father's name _____ Home Phone _____

Address _____ Work Phone _____

City & Zip _____ Employer _____

How did you hear of our school ? _____

What do you want your child to gain from this experience? _____

Is there any unusual feature in your child's home or history that would be useful in helping us understand or communicate with him or her?

Does anything about your child's actions cause you concern ? _____

If your child has attended other schools or programs briefly describe his or her experiences.

Health Information

Is general health good ? _____

Height _____ Weight _____ Is child toilet trained ? _____

Last physical examination was on _____

Last dental examination was on _____

Health Concerns that might limit your child's full participation in school activities:

Surgery, past illnesses or special problems _____

Allergies (bee, food, pollen, medicine) _____

Health conditions (heart, asthma, diabetes, seizures) _____

Any Current Daily Medications ? _____

Other (delayed speech development, unusual social responses, sensory integration delays, etc.)

FAMILY DOCTORS/PEDIATRICIANS

Clinic _____ Phone _____

Family Doctor's Name _____

Pediatrician's Name _____ Phone _____