First Baptist Weekday Preschool

About Your Child

What foods does your child especially like/dislike?_____

Favorite toys, games activities?_____

Is your child toilet trained?_____ What word(s) does your child use for toilet?_____

Can your child go by him/herself?_____ Does your child have frequent accidents?_____

How does your child express anger or frustration?_____

Does your child bite?_____ If yes, please explain circumstances_____

Does your child have any special fears?____ Explain_____

Is your child frightened of noises?_____

How is your child best comforted?_____

How do you discipline your child?_____

Special family situations (custody, guardianship, etc.)_____

Anticipated adjustment problems_____

Any suspected or diagnosed disorders/developmental delays?_____

Primary language spoken in the home_____

Describe child's speech (length of sentences, clarity)_____

Your expectations of FBC Weekday Preschool_____
_____

How did you hear of our school?_____

Please check holidays your family celebrates: ____Thanksgiving ____Christmas
____New Year's Day ____St. Patrick's Day _____Purim _____Easter
____Valentine's Day ____Hanukkah ____Chinese New Year
____Halloween ____Other:_____

Would you be willing to share your special holiday with the class?_____

Health History

Has your child had any of the following? (please check)

____Asthma ____Bronchitis ____Chicken Pox ____Convulsions

____Hepatitis ____Diabetes ____Measles ____Fainting spells ____Ringworm

____Frequent Colds ____Skin Rashes ____Heart trouble ____Nose Bleeds

____Urinary Problems ____Scarlet Fever ____Mumps ____Tuberculosis

____Stomach Upsets ____Whooping Cough ____Frequent Sore Throats

____Frequent Ear Infections ____Febrile Seizures

Please explain yes answers:_____

_____

Other?_____

Has your child ever been hospitalized? ____ Explain_____

_____

Last vision test_____ Last hearing Test_____

Last Dental Visit_____ Last Tetanus Shot_____

Child's Physician_____ Phone Number_____

Have any members of your family had a serious illness recently?_____

Family History of: _____Asthma _____Diabetes _____Epilepsy
Other:_____

List all known food/drug/other allergies_____

Other pertinent medical/behavior information_____

Signature of parent/guardian_____