



2016-2017 Background Information for Preschool Students

Family History

Child's Name _____

Name child prefers to be called _____

Birth date _____ Gender _____

Names of Parents or Guardians _____

Siblings:

Name _____ Age ____ Name _____ Age ____

Name _____ Age ____ Name _____ Age ____

Are there other members of the household? List name, age and relationship _____

For statistical purposes:

Is your family: Jewish One Jewish Parent (Interfaith) Non-Jewish

Health History

Does your child have any health problems that we should be aware of, such as congenital malformations, heart disorders, asthma, and pneumonia? _____

Please explain _____

Was your child born prematurely? Were there birth complications? Please explain _____

Does your child have any problems with vision or hearing? _____

Does your child frequently have any of the following?

Cold Sore throats Earaches Stomachaches Fevers

Has your child ever had chicken pox? _____ Date: _____

Has your child had any serious accidents or operations? If so, please describe: _____

Does your child have any allergies? _____ Please describe: _____

Are there any foods or drinks that your child should not have? _____

Does your child take any regular medication? _____

****If medication (Emergency medication only) needs to be left at school, proper documentation must be filled out by you and your child's physician. Forms are available in the TRSNS office and online at trnsnoffice.shutterfly.com and the Temple Rodef Shalom Website. ****

OVER

Developmental History

Is your child toilet trained? ____ Describe assistance needed and words used. _____

Do you think your child's speech is clear? _____

Can strangers understand when he or she speaks? _____

Is any language other than English used in the home? If so, please describe _____

Do you have any concerns about any aspect of your child's development? _____

Other

Does your child nap? ____ When? _____

What time does your child go to bed at night? _____ Wake up? _____

Does your child have any special fears? _____

What does your child usually eat for breakfast? _____

What are your child's favorite activities? _____

What does your child enjoy doing with each parent?

Does your child play well alone? _____ In groups? _____

Are there neighborhood playmates? ____ If so, with what age children does your child usually play? _____ Does your child accept correction easily? _____

What is the method of behavior guidance used in your home? _____

Please circle words below that describe your child:

Happy Aggressive Friendly Moody Clumsy Athletic Dependent Independent
Impulsive Stubborn Easy-Going Fearful Quiet Verbal Good-natured Shy Outgoing
Attentive Sympathetic Even-tempered Other:

Has your child been cared for by someone besides the family? ____ If so, please describe: _____

Has your child gone to preschool or daycare before? ____ Please describe previous experiences. _____

What do you hope will be included in your child's preschool program?

The information on this form will enable the teacher to better understand your child.