Deerfield Park District Preschool

FORM #3 **CHILD'S PERSONAL/HEALTH HISTORY**

NEW STUDENTS FOR 2021-2022

Check (V) ☐ **LITTLE LEARNERS** *(3 years old by 5/1)* ☐ **3 YEAR OLDS** *(3 years old by 9/1)* ☐ **PRE-K 4's** *(4 years old by 9/1)*

(Please Print)

Child's Last Name _____ First Name _____

Home Address _____ City _____

Birthdate ____ / ____ / _____ *Gender:* Male ☐ Female ☐ Nickname *(if applicable)* _____

Student Directory: Email _____ Cell # _____

What school will your child attend for **KINDERGARTEN?** _____

FAMILY / HOME

Parent/Guardian Name _____ Occupation _____

Business Phone _____ Work Hours Mon _____ Tue_____ Wed_____ Thu_____ Fri _____

Do you travel for business? _____ If yes, how often?_____

Parent/Guardian Name _____ Occupation _____

Business Phone _____ Work Hours Mon _____ Tue_____ Wed_____ Thu_____ Fri _____

Do you travel for business? _____ If yes, how often?_____

Parent's Marital Status: Single ☐ Married ☐ Separated ☐ Divorced ☐ Other: _____

If divorced or separated, which parent does your child reside with? _____

How often does child see *other* parent? _____

Name of Sibling (s)	M/F	Date of Birth *(include year)*	Preschool Attended *if applicable)*	Current School / Grade *(if applicable)*
_____	___	_____	_____	_____
_____	___	_____	_____	_____

Does anyone else live in your home? YES____ NO____ If yes, name/relationship to child: _____

_____

Is ENGLISH your child's primary language? YES ☐ NO ☐ If no, what language does your child speak? _____

Are any other languages spoken in the home? YES☐ NO☐ If yes, what language? _____

HEALTH HISTORY

Has your child had any injuries, surgeries or recent personal family traumas? YES☐ NO☐
If yes, please explain:

Is your child prone to certain illnesses or have any conditions we should be aware of? YES☐ NO☐
If yes, please explain:

Does your child currently receive *(or has received in the past)* outside services or therapies? *(i.e.: Speech, OT, PT)*
YES☐ NO☐
If yes, please explain:

Does your child take any medication regularly? YES☐ NO☐
If yes, please list and explain:

Will your child need to take medications while at school? YES*☐ NO☐ **If yes, must complete Medical Distribution Form*
If yes, please list and explain:

Are school snacks a potential concern? YES☐ NO☐
If yes, please explain:

Are there any toileting or use of bathroom concerns that may affect your child at school?

ALLERGIES: Complete below if your child has allergies

Allergy to	Contact or Ingestion	Symptoms	Medication Needed	Life Threatening?
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

SCHOOL / GROUP EXPERIENCE

Is your family **NEW** to our Preschool? YES☐ NO☐

Is this your child's first school experience by themself? YES☐ NO☐

Name(s) of schools child attended w/o adult: *(if applicable)* Day/hours attended: Dates attended:

1. _____ _____ _____

2._____ _____ _____

SOCIAL EMOTIONAL HISTORY

How would you describe your child's temperament/personality?

How does your child handle separation?

Are there specific situations in which your child tends to become upset, angry, scared, or withdrawn?

Describe your child's attitude toward other adults? *(i.e.: friendly, outgoing, cautious, etc.)*

How would you describe your child's play? *(i.e.: self-initiated, plays alone, prefers to play with others, active, quiet, etc.)*

YOUR INPUT

What are your goals for your child at Preschool?

Is there any other information that you would like to share with the staff (directors or teachers)?

Date: ____ / _____ / _____ Parent/Guardian Signature _____