

FORM #3

Deerfield Park District Preschool
CHILD'S PERSONAL/HEALTH HISTORY
NEW STUDENTS FOR 2023-2024

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

(Please Print)

Child's Last Name _____ First Name _____

Home Address _____ City _____

Birthdate ____ / ____ / ____ Gender: _____ Nickname (if applicable) _____

Student Directory: Email _____ Cell # _____

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

FAMILY / HOME

Legal Guardian Name _____ Occupation _____

Business Phone _____ Work Hours Mon _____ Tue _____ Wed _____ Thu _____ Fri _____

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

Legal Guardian Name _____ Occupation _____

Business Phone _____ Work Hours Mon _____ Tue _____ Wed _____ Thu _____ Fri _____

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

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

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

How often does child see *other* caregiver? _____

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 themselves? 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: ____ / ____ / _____ Legal Guardian Signature _____