

Abiding Savior Lutheran Preschool
Getting to Know Your Child and Your Family Life

Date: _____

Child's Full Name: _____ BOY GIRL

Name used at school: _____ Date of Birth: _____

Child's Street Address: _____ City: _____ Zip: _____

Home Phone #: _____ E-mail Address: _____

Mother's Name: _____ Occupation: _____

Cell #: _____ Work #: _____

Dad's Name: _____ Occupation: _____

Cell #: _____ Work #: _____

Current Marital Status of Child's Parents: _____

Names of others living in the home	Age (if child)	Relationship to Child
_____	_____	_____
_____	_____	_____
_____	_____	_____

Developmental History

1. Was your child premature? YES NO

2. Were there any difficulties during birth? YES NO

3. Are there any difficulties with hearing or eyesight? YES NO

4. Any speech delays or difficulties? YES NO

5. Is your child currently in speech therapy? YES NO If so, how long? _____

6. Does your child speak/understand English? YES NO

7. What language is spoken in the home, if other than English? _____

8. Are there any allergies i.e. food, medications, environmental, etc? YES NO

If YES, please list: _____

9. Does your child need to use an EPI – PEN? YES NO

If YES, when is the EPI-PEN needed?

10. Does your child drink a special kind of milk, due to food allergies? YES NO

If YES, what type of milk?

11. Are there any other conditions requiring special attention here at preschool?

YES NO

12. Does your child have frequent colds? YES NO

13. Does your child have frequent ear infections? YES NO Ear Tubes? YES NO

14. At what age did your child: crawl _____ walk _____ begin to talk _____

begin toilet training _____

15. Sleep Patterns: Get-up time _____ Nap time _____ Bed time _____

16. Does your child have any fears? YES NO

If so, what?

17. Do you discipline your child? YES NO

18. If so, what methods do you use to discipline?

19. How do you expect your child to be disciplined here at school?

20. Is your child able to separate easily from you? YES NO

21. Has your child been babysat? YES NO If so, how often? _____

Social & School Experiences

1. Please circle the places your child has visited.

Parks	Mountains	Desert	Ocean	Hospital	Office Building	
Church	Sunday School	Grocery Store	Train Station	Museum		
County Fairs	Library	Airport	Zoo	Circus	Disneyland	Farm/Ranch

2. Has your child traveled to other places? YES NO
If so, where?

3. Is this your child's first school experience? YES NO
If not, where did your child attend? _____
How long? _____

4. What OUTDOOR activities does your child enjoy?

5. What INDOOR activities does your child enjoy?

6. Is your child read to on a daily basis? YES NO If not, how often? _____

7. What is your child's favorite story or book? _____

8. Does your child watch television? YES NO If so, what program or programs?

9. Does your child use the computer? YES NO If so, how is it used? _____

10. Are there any extra-curricular activities your child is involved in? If so, what are they?

11. I'm a church member at: _____

12. Has your child been: Baptized or Dedicated

If so, where and when? _____

13. If you would like to share any other information, please use the back of this sheet.

Thank you! 😊