Congregation Beth Shalom Preschool
New Student Supplemental Application Information

Child's Name_____ Date of Birth_____ Gender ❍ M ❍ F

HOUSEHOLD ADJUSTMENT

Has your child experienced any of the following? Please check all that apply.

❍ Household Moves ❍ Change in Caregiver ❍ Parental Job Changes ❍ Death in Family ❍ Parent Work Hours Change ❍ Loss of Pet ❍ New Baby ❍ Serious Illness ❍ Hospitalization ❍ Operation ❍Accident ❍ Serious Injury ❍ Parent Attending School ❍ Other_____

What was child told about family changes?_____

How did s/he react?_____

How does your child handle changes in routine?_____

How does your child react to new situations?_____

Please note specific situations in which your child tends to become upset, angry, afraid or withdrawn.

_____

_____

Describe how you help your child handle these situations? _____

_____

What do you like about your child?_____

How would you describe your child's temperament or personality?_____

Does your child exhibit any of the following behaviors? ❍ hitting ❍ biting ❍ pulling hair ❍ pushing

Describe your approach to discipline and how your child responds_____

_____

PLAY HABITS

What are your child's play habits?_____

_____

Does your child make friends with children easily or cautiously?_____

Does your child make friends with adults easily or cautiously?_____

How would you describe your child's attitude towards adults? ❍ Friendly ❍ Aggressive ❍ Shy

Would you describe your child's play as ❍ Active ❍ Boisterous ❍ Quiet ❍ Self-initiated

Does your child have playmates? _____How many?_____ Gender?_____

How does your child interact with playmates?_____

_____

How does your child get along with his/her siblings?_____

_____

What does your child enjoy doing with other members of the family?_____

_____

Does your child have any special family interests or hobbies?_____

_____

GENERAL HEALTH

Does your child have any problems in the following areas? if so please describe.
If yes, please describe. (Required)

❍ Yes ❍ No Allergies_____
❍ Yes ❍ No Vision_____
❍ Yes ❍ No Hearing_____
❍ Yes ❍ No Ear infections - How often?_____ Fluid? ❍ Yes ❍ No
❍ Yes ❍ No Coordination_____
❍ Yes ❍ No Food Restrictions_____
❍ Yes ❍ No Eating Difficulties_____
❍ Yes ❍ No Constipation_____
❍ Yes ❍ No Diarrhea_____
❍ Yes ❍ No Seizures_____

Does your child use adaptive equipment, medical or health equipment (tubes, glasses)? ❍ Yes ❍ No

Does your child take medication regularly? ❍ Yes ❍ No

Please describe_____

Any special instructions?_____

ROUTINES

Does your child speak English? __ Yes __ No Is English your primary language? __Yes __ No

Does your child speak any other language? If so, what language(s)? _____

Is this your child's first preschool experience? ❍ Yes ❍ No

If no, what was previous experience?_____

Where?_____ How long did s/he participate? Days/Week_____

How did your child transition?_____

Why did experience end?_____

Does your child have difficulty with separation? _____

DEVELOPMENT

At what age did s/he? *(If you can't recall the age but your child has mastered the skill, just check it.)*

Crawl_____ Walk_____ Point_____ Babble_____

Use Single Words_____ What were first words?_____

Use Phrases_____ What were first phrases?_____

Are there any aspects of your child's development that are of concern to you?_____

_____

Are there any other professionals/agencies working with your child/family? ❍ Yes ❍ No

Collaboration is necessary for successful service delivery for your child. Please list professionals/agencies names and numbers for us to collaborate with them._____

_____

_____

SLEEPING

Please indicate your child's sleep habits with a check. Does your child:

❍ Use a bottle ❍ Use a pacifier ❍ Thumb suck ❍ Sleep in a crib ❍ Sleep in a bed ❍ Sleep alone

❍ Sleep with toy ❍Sleep with blanket ❍ Fall asleep easily

❍ Go to sleep with difficulty? How do you handle? _____

_____

❍ Have nighttime rituals_____

_____

❍ Have nighttime fears_____

TOILETING

At what age did s/he? Start B.M. Training _____Start bladder training_____

Method of training_____

Does your child tell you ❍ before ❍After or ❍ do you need to remind him or her.

Does s/he mind using toilets outside the home? ❍ Yes ❍ No

If "accident" what reaction?_____

EATING

Are mealtimes: ❍ Pleasant ❍ Difficult Please describe_____

How do you handle it?_____

What are your child's favorite foods?_____

What foods does your child dislike?_____

When does s/he usually get hungry?_____

How often does your child eat during the day?_____

OTHER

Is there any other information you would like to provide? _____

_____

_____

PARENT/GUARDIAN SIGNATURE _____ Date _____

Omission and/or falsification of any information required in this profile is grounds for immediate dismissal from the program.