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Please note specific situations in which your child tends to become upset, angry, afraid or withdrawn.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