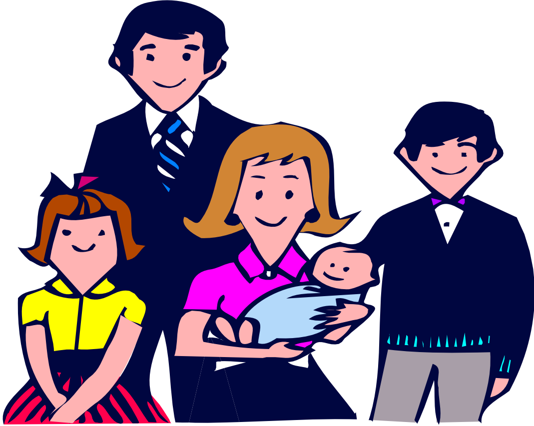

Family Information Report

Please complete the following sheets as best you can so that we may know your child as well as possible.

Name of child________________________ Date of Birth ____________________

Does your child have a nickname? _____________________________

List names and ages of any other children in the family:
1.
2.
3.
4.

List names of any other people who reside in the home:
1.
2.
3.

Parents marital status (circle one)

Married Separated Widowed Divorced Other

Language spoken at home: ___________________________________

Has your child been screened for speech, emotional, or behavioral difficulties? ________
If yes, please explain. ____
____
____.

Family and medical history

Illnesses: meningitis ___ encephalitis _____ Allergies __________

Head injuries ______ Ear infections _________ Asthma __________

Please list other illnesses or hospitalizations:
____
____.

Has your child had a vision or hearing test outside of school?
____.

Does your child wear glasses? ____.

Does your child take any prescription medication daily?
____.

Development

	Not Yet	just beginning	well
Ties shoes	________	___________	________
Throws ball	________	___________	________
Catches Ball	________	___________	________
Works puzzle	________	___________	________
Cuts with scissor	________	___________	________
Colors within lines	________	___________	________
Builds with blocks	________	___________	________

Language

	Age
Spoke first words	__________
2 or 3 words together	__________
Clear sentence structure	__________

Follows one step directions with out being reminded? Yes No

Toileting

	age
Bowel control	________
Bladder control	________
Goes to toilet alone	yes ___ no ____
Bed wetting	yes ____ no ____

If yes, how often? ____________________________

Sleeping

	yes	no	comment
Difficulty falling asleep	____	____	______________________
Frequent awakening	____	____	______________________
Early AM awakening	____	____	______________________
Sleep walking	____	____	______________________
Nightmares	____	____	______________________
Does your child share a room?	____	____	______________________

Amount of sleep per night? _________________________________

What is a typical bedtime? __________________________________

Eating

	Comment
Is your child a good eater?	____
Are there any food allergies?	____
Are there any food restrictions?	____
Does your child feed his/herself?	____

Behavior

	Yes	No	Comment
Takes turns with others	_____	_____	________________________
Takes care of toys	_____	_____	________________________
Self-reliant	_____	_____	________________________
Cooperative	_____	_____	________________________
Strong-willed	_____	_____	________________________
Energetic	_____	_____	________________________
Hyper active	_____	_____	________________________
Impulsive	_____	_____	________________________
Sense of humor	____	_____	________________________
Separates from parents easily	_____	_____	________________________
Shy	_____	_____	________________________
Aggressive	_____	_____	________________________
Talkative	_____	_____	________________________

General Information

What is your child's favorite color? ____

What is his/her favorite TV show?____

How much TV does your child watch per day?__________________________________

Do you censor his programs?____

Does he/she like to be read to?____

What are his/her favorite stories?____

Is there a pet in the house? ____

Has your child attended any nursery, pre-school centers, camps, etc?

____

What types of experiences do you feel will be most beneficial to your child at our school?

____

____

____

Is there any other information which you believe might be helpful to us in understanding your child?

____

____

____

____

____

____