

Help Us Know Your Child

Sunbeams Nursery School

253 Myers Corners Road
Wappingers Falls, NY 12590
845-297-3408



Child's Name: _____ Nickname: _____

Date of Birth: _____ Place of Birth: _____

Address: _____

Religion: _____ Church Affiliation: _____

Father's Name: _____ Occupation: _____ email: _____

Mother's Name: _____ Occupation: _____ email: _____

Marital Status of Child's Parents: _____

List other children in the family:

_____ Age: _____ _____ Age: _____

_____ Age: _____ _____ Age: _____

List other members of the household and their relationship to this child:

_____ Relationship: _____ _____ Relationship: _____

Names and types of pets: _____

Health History

What illnesses has your child had? At what age?

Chicken pox: _____ Scarlet Fever: _____ Other: _____

How often does your child suffer from the following illnesses?

Colds: _____ Ear Infections: _____ High Fevers: _____

Vomiting: _____ Allergies: _____ Respiratory Infections: _____

Please explain any chronic illness or condition, operation, or hospital stay that your child has had:

Does your child have any adverse feelings towards his physical disabilities, chronic illness, etc? (If yes, please explain)

Development

Does your child have speech problems? _____ If so, what? _____

Does your child dress independently? _____ If not, with what does he require assistance? _____

Do you feel that your child is advanced in some areas? _____ If so, explain: _____

Do you feel that your child is slower in some areas? _____ If so, explain: _____

Habits

Is your child left-handed or right-handed? Left Right

List your child's special fears. _____

List your child's special interests and travel experiences.: _____

What methods of discipline have you found most effective? _____

How does your child indicate bathroom needs? _____

How often does your child have toileting accidents? _____

Play & Social Relationships

What activities does your child enjoy with...

Mother: _____

Father: _____

Siblings: _____

What age and sex are your child's most frequent companions? _____

Does your child have an imaginary playmate? _____

Does your child play alone? Never Occasionally Often

Does your child hear stories? _____ From whom? _____

Please describe your child's favorite pasttime(s). _____

Check the areas that your child has had experience with:

- | | | | |
|--|---------------------------------------|--|--|
| <input type="checkbox"/> scissors | <input type="checkbox"/> stapler | <input type="checkbox"/> puzzles | <input type="checkbox"/> tape recorder |
| <input type="checkbox"/> glue | <input type="checkbox"/> crayons | <input type="checkbox"/> clay | <input type="checkbox"/> water paint |
| <input type="checkbox"/> tempera paint | <input type="checkbox"/> finger paint | <input type="checkbox"/> musical instruments | |

What would you like your child to gain from this nursery school experience? _____

Please provide any additional information which might be helpful to us. _____