Roslyn-Trinity Cooperative Day School

PERSONAL INFORMATION FORM

This questionnaire is confidential and shall be read only by our staff members. The information we seek is for the purpose of helping us gain the broadest possible understanding of your child so that we may meet his or her individual needs in an enlightened way.

Today's date: _____

CHILD'S NAME: _____ NICKNAME: _____
First Last

Birthdate: _____ Gender: _____

Age in **September**: _____ years _____months

If any question requires more space than is allotted, please use the back page.

1. Does your child participate in any organized programs other than the Co-op? If so, please list.

2. Is your child experiencing any speech difficulties?

3. Is any language other than English spoken at home?

4. At approximately what age did he/she become toilet trained?_____
Is there anything we should know about his/her toilet habits? Are special toileting words used in your home?

5. How does he/she get along with other children? Is he/she cooperative, dominant, passive, able to share or more interested in solitary play?

6. How does each parent feel in regard to discipline? What methods are usually used at home?

7. In your child's lifetime, have there been any incidences of severe illness, hospitalization, surgery or death of any family member? If so, would you please tell us how she/he was prepared if at all? Who stayed with the child if a parent was hospitalized? Were there any subsequent reactions?

8. Was your child ever hospitalized? How long was he/she in the hospital? Did a parent stay with the child? What was his/her reaction?

9. Please list all allergies. Has your child suffered from convulsions, asthma attacks or severe allergic reactions? Does your child require emergency medication for his/her allergy (e.g., Benadryl, EpiPen)? Please describe.

10. Does he/she have any physical disabilities? Please describe.

11. Is your child receiving any outside services, e.g.,

	No. of Hours/Week	Name of Provider/Agency
Speech		
Occupational Therapy		
Physical Therapy		

12. Will your child be receiving special education itinerant services (SEIT) in September?
If so, No. of Hours/Week Name of Provider/Agency

13. Does your child have fears of the dark, animals, noise, new situations, bodily injury or other things? Please describe the fears and tell us how you handle this.

14. Most children this age release their tensions in various behavioral characteristics. Does your child bite his/her nails, masturbate, pick his/her nose, suck his/her thumb, pull or twist hair, etc. or have any other such habits? Please describe them, and if so, how have you handled this?

15. Please list <u>all</u> household members who reside with the child (parents, siblings, relatives, caregivers).

NAME	RELATIONSHIP	AGE

16. Are there any siblings who do not reside in the home?

17. How does your child get along with other siblings?

18. What are parent's occupations? Hobbies? Are you willing to have your child's class visit you at work? Can you share a hobby with your child's class?

19. Are there any special cultural customs or traditions your family celebrates?

20. If your child does not live with both parents, please explain the circumstances and visiting arrangements.

21. Is the family expecting a new baby? If so, when?

22. If there is a new baby in the household, please describe how your preschooler was prepared for its arrival and how he/she reacted.

23. Has your family moved recently? If so, how was the child prepared and how did he/she react? Are you planning to move in the near future?

24. Who usually stays with your child in the parents' absence and how does the child react?

25. If your child has an imaginary playmate, please describe.

26. Is there a pet in the home? If so, what kind and what is the name?

27. What type of play does your child enjoy most?

28. How much time each day does your child spend on screen time (watching TV, playing video games, using an iPad, etc.)? _____
Which programs are usually viewed?

29. Does your child tire easily? _____ How does he/she show it?

30. Does your child sleep through the night?_____
Bedtime _____ Rising time _____ Nap time (if any)_____

31. Does your child have any special eating problems?

32. Please indicate if he/she has a preference for right or left hand in most activities.

33. Please underline those words which are most descriptive of your child's behavior most of the time or add any which you feel are appropriate: friendly, calm, excitable, easily angered, whining, crying, happy, easily frustrated, cooperative, negative, quiet, positive, withdrawn, aggressive, fearful, tense, independent, anxious, passive, sociable, cautious, enthusiastic.

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Please use the bottom of this page to give us any other information which you think will help us know your child better and better meet your child's educational needs. Are there any special ways in which you feel the school can help him/her? Are there any personal characteristics which you would like to see encouraged or discouraged?

Is there anything you would like to speak to your child's teacher about that might help us to be more sensitive to your child's needs? If so, please call the school and arrangements will be made for the teacher to speak with you.