First Kids FAMILY HISTORY

Family History of _____
Last First Middle Nickname

Address _____ City _____ Zip _____

Phone _____ Birth Date _____ Sex ____
Home Cell

Please take time to complete the following information. We have found that the more we know about your child and your family, the more we will be able to assist with your child's adjustment to our school.

Put 'Y' for yes and 'N' for no to the following questions.

Does your child feed himself/herself? _____	Goes to bed easily? _____	Choose his/her clothes? _____
Potty-trained? _____	Dresses himself/herself? _____	Has his/her own bedroom? ____
Goes to bed alone? _____	Helps with chores? _____	Helps clean his/her room? _____

Has your child attended any other schools? Include the age of your child and how long he/she was in attendance:
_____

List names and ages of siblings: _____

Are there any other people living in the home with your family? If so, list: _____
_____

Main language spoken at home? _____ Any other languages?_____

Family pets (Names and types of animals): _____

Were there any special circumstances surrounding your child's birth such as premature birth, early trauma, early illness, adoption, prolonged hospitalization, etc.? If yes, please explain: _____
_____

Have you detected any difficulties in: Hearing?_____ Sight?_____ Speech?_____ Other?_____
Any early intervention? (speech, physical and/or occupational testing or therapy) _____
If yes, by whom and elaborate on services received: _____
_____

Does your child have any special attachments such as a blanket, pacifier, thumb, etc.? If yes, explain: _____
_____

List discipline procedures found to be most effective with your child and why: _____
_____

Child's favorite activities or interests: _____

Child's favorite foods: _____

Child's favorite toys: _____

Favorite book or cartoon character: _____

Does your child show a preference for the right or left hand? Right____ Left____ Not yet____

Does your child nap? Yes ___ No___ If so, When? _____ How Long? _____

(Over)

Last First

SPECIAL CONCERNS:

Health _____

Is your child on medication? _____ Reason _____

Side effects _____

EPI Pen_____ Sun sensitivity_____

Operations _____

Serious Illnesses _____

Allergies _____

_____

_____

Birthmarks or other unusual markings on skin _____

Does your child run a temperature easily? _____

Is your child subject to: (check all that apply)

High temperatures _____ Convulsions _____ Visual difficulties _____ Speech difficulties _____
Hearing difficulties _____ Nosebleeds _____ Earaches _____ Headaches _____ Asthma _____
Stomach problems _____ Epilepsy or seizures _____ Urinary, kidney, bowel difficulties _____

MORE ABOUT YOUR CHILD:

What are you most interested in seeing develop in your child? _____

How would you describe your child's personality? _____

Family experiences that have influenced your family and child, such as a recent move or death:

_____

_____

Is your child afraid of anything? _____

If so, how are you dealing with it?_____

Now take it from here and tell us about him/her. Is s/he imaginative, jealous, talkative, independent?

_____

_____

_____

_____

_____

I understand that a staff member will be available for conferences upon requests by the parents. I also understand that special problems or occurrences affecting a child will be brought to the attention of the parents, including communicable diseases.

Signature – Parent or Legal Guardian_____ Date _____

The information given to us about your child is confidential and will be shared only with your child's teachers and the administration.