



Great Beginnings Preschool Student Information Form

Child's Name _____ Nickname _____
Age _____ Birthdate _____

Personality

Child's nature: (Please circle all that apply)

Friendly Aggressive Cooperative Happy Shy
Withdrawn Affectionate Competitive Angry Other _____

Child's Fears: (Please circle all that apply)

Strangers Animals Dark Storms Loud noises
Other: _____

Has your child had any previous school/group/class experience? _____

Describe: _____

How does your child show feelings? _____

Is your child particularly verbal? _____

Is your child a leader or a follower? _____

Is your child patient or impatient? _____ Whines? _____

Does your child usually do what is asked of him/her? _____

Does your child take a nap? _____

How many hours does your child sleep at night? _____

Describe your child's appetite: _____ always hungry _____ never hungry _____ eats at mealtime
 _____ snacks _____ snacks all day _____ has to be coaxed to eat

Are there any foods your child may not or can not eat? (allergies, religious customs, etc.) _____

Please list: _____

Hand preference: right / left / both _____

Home Experience

Household members and relationship: _____

Names and ages of siblings _____

Pets (name and type)? _____

Parents church affiliation? _____



SOCIAL SKILLS

Does your child have experience playing with other children? _____

Does your child like to share? _____

Does your child watch TV? _____ What shows? _____

What are your child's interests (singing, painting, stories, trucks, pets, music, outside play, coloring, dolls/house)? _____

Does your child have previous experience in any of the areas listed below? (circle all that apply)

- | | | | | |
|---------|----------------------|------------|-----------------|---------|
| clay | dancing | water play | finger painting | cutting |
| blocks | coloring | pasting | writing name | letters |
| Numbers | listening to stories | | | |

SPEECH

Does your child use any special words to describe needs? _____

Does your child use any special word for toileting? _____ Please state: _____

Does your child speak plainly so that others, besides those at home can understand? _____

Which foreign languages, if any, are spoken in the home? _____

HEALTH

Does your child have allergies? (drugs, seasonal, food, etc.) _____

Please describe reaction _____ Treatment : _____

Does your child have asthma or other respiratory ailments? _____ Inhaler? _____

Congenital Malformations _____ Heart disease _____

Is there any other medical condition that we should know to properly care for your child? _____

OTHER

What are you hoping to have your child gain from his/her preschool experience? _____

Would you be interested in volunteering in the classroom? _____ If so, in what capacity? _____

Is there anything else you would like to share with us that you think would help us in teaching your child? _____

Thank you for taking the time to complete this form!