ARDMORE PRESBYTERIAN WEEKDAY PRESCHOOL
STUDENT QUESTIONNAIRE

VITAL STATISTICS:

Child's Birth Date

Today Date:

Child's First Name

MI

Last Name

Home Address

Home Phone

Father Name

Address (if not the same as child

Father's Occupation

Office Phone:

Office Address

Father's Cell Phone

Father's E-Mail

Name of Mother

Address (if not the same as child

Mother's Occupation

Office Phone

Office Address

Mother's Cell Phone

Mother's E-Mail

Name of Pediatrician

Phone

Address

Name of Dentist

Phone

Address

Name of Neighbor or Relative: (If unable to reach parents.)

Phone

Cell

Address

How did you hear about our school?

FAMILY DATA

Other children and persons living in the home

Name	Age	Relationship

Church Affiliation of Father

Church Affiliation of Mother

Areas of Interest of Father

Areas of Interest of Mother

HEALTH

Handicaps (eyes, ears, feet, etc.)

Allergies

Is child left-handed ☐

Is child right-handed ☐

Is child both ☐

Is child presently taking any medication

◯ Yes

◯ No

How many visits was child taken to the doctor during the past year?

For what reason?

List congenital conditions, unusual injuries, operations and/or traumatic experiences which child had

List food that child is unable to eat (medical reasons, allergies, etc.

Which of the following does your child now have or is prone to?

Speech difficulties
- ◯ Yes
- ◯ No

Hay Fever
- ◯ Yes
- ◯ No

Nail Biting
- ◯ Yes
- ◯ No

Asthma
- ◯ Yes
- ◯ No

Persistent Crying
- ◯ Yes
- ◯ No

Finger Sucking
- ◯ Yes
- ◯ No

Toilet Difficulties
- ◯ Yes
- ◯ No

Sore Throat
- ◯ Yes
- ◯ No

Eating Habit Problems
- ◯ Yes
- ◯ No

Drug Reaction
- ◯ Yes
- ◯ No

Temper Tantrum
- ◯ Yes
- ◯ No

Mouth Breathing
- ◯ Yes
- ◯ No

Epilepsy Attacks
- ◯ Yes
- ◯ No

Frequent Colds
- ◯ Yes
- ◯ No

Eye complaints
- ◯ Yes
- ◯ No

Earaches/ Discharges
- ◯ Yes
- ◯ No

SOCIAL DEVELOPMENT

Has child played with others his/her own age?

How does child get along with other children?

Does child accept other adults, besides members of the family (for example baby-sitters)?

What previous group experiences has child had?

Does child have any known special gift or talents?

How many hours a day does your child watch television?

What is your child's favorite television program?

Do these words describe your child's characteristic behavior?

Shy	Friendly	Fearful	Aggressive
◯ Yes	◯ Yes	◯ Yes	◯ Yes
◯ No	◯ No	◯ No	◯ No

PARENTAL CONCERNS

What goals do you have for your child?

Short Term

Long Term

What experiences would you like your child to have in preschool?

Are there any specific concerns you would like to mention?

Is there any specific problem you would like to describe?

EMOTIONAL BEHAVIOR

Do these emotions generally apply to your child:

Easily angered	Tearful, cries easily	Excitable	Easily Tired
◯ Yes	◯ Yes	◯ Yes	◯ Yes
◯ No	◯ No	◯ No	◯ No

Fears (be specific):

Types of home discipline most often used

How does child react to discipline?

Please give any information that might help us to work with child

Likes:

Dislikes:

Unusual Habits:

Strong attachment to toy or other object:

Thank you,
The Preschool Staff