TEACHER'S CONFIDENTIAL INFORMATION SHEET

CHILD'S NAME:_____NICKNAME:_____

ADDRESS:_____HOME PHONE:_____

BIRTHDAY:_____Age by Sept._____yrs._____mos. SEX:_____

SCHOOL DISTRICT:_____ KINDERGARTEN YOUR CHILD WILL ATTEND:_____

EMAIL ADDRESS FOR COMMUNICATION, NEWSLETTER, & UPDATES:_____

MAILING ADDRESS (if different from above):_____

PARENTS' NAMES (first and last): _____cell:_____

_____cell:_____

Parent 1 employed by:_____Phone:_____

Parent 2 employed by:_____Phone:_____

IF WORKING, (babysitter):_____Phone:_____

MARITAL STATUS: married_____, separated_____, divorced_____, widowed_____

NAMES AND AGES OF SIBLINGS:_____, age_____, _____, age_____

_____, age_____, _____, age_____

NAME OF FRIEND OR NEIGHBOR:_____Phone:_____

CHILD'S PHYSICIAN:_____Phone:_____

ALLERGIES OR DIETARY RESTRICTIONS:_____REACTION:_____

MEDICATIONS TAKEN REGULARLY:_____

IS YOUR CHILD BILINGUAL?_____ If yes, what language?_____

WHO WILL USUALLY BE BRINGING CHILD TO AND FROM SCHOOL?_____

IS THIS YOUR CHILD'S FIRST EXPERIENCE AWAY FROM YOU? _____

IF NOT, PLEASE DESCRIBE PREVIOUS EXPERIENCE_____

WHAT IS THE MOST IMPORTANT THING WE NEED TO KNOW ABOUT YOUR CHILD?_____

_____

IS YOUR CHILD FULLY POTTY TRAINED?_____

DOES YOUR CHILD HAVE ANY FEARS WE SHOULD KNOW ABOUT?_____

_____

WHAT IS THE BEST WAY TO COMFORT YOUR CHILD? _____

_____

ARE THERE ANY ACTIVITIES THAT MAKE YOUR CHILD UNCOMFORTABLE? _____

_____

WHAT TOYS/ACTIVITIES DOES YOUR CHILD LOVE? _____

_____

HOW WOULD YOU DESCRIBE YOUR CHILD'S EATING AND SLEEPING HABITS?_____

_____

WHAT WOULD YOU LIKE YOUR CHILD TO GAIN FROM THIS PRESCHOOL EXPERIENCE?_____

_____

DO YOU HAVE ANY CONCERNS THAT YOU WOULD LIKE US TO KNOW ABOUT?_____

_____

DEVELOPMENTAL HISTORY: (Please complete as accurately as you can remember.)

BIRTH HISTORY: Typical?_____, Any remarkable history?_____

Adopted?_____ When?_____, Does child know?_____

MOTOR DEVELOPMENT: (when child sat up, walked, etc.) Typical?_____, Any remarkable history?_____

_____

SPEECH DEVELOPMENT: Typical?_____, Any remarkable history?_____

Any speech/language problems at present?_____

_____

SLEEPING HABITS: Normal_____, Any long periods of sleep disturbances?_____

Presently_____

EMOTIONAL DEVELOPMENT: Has child any fears or anxieties which have been of long duration?_____

_____

Any exceptional experience that you know of that may have distressed the child (long illness, death in family, separation from parent, etc.)_____

_____

Any hospital experience?_____, When?_____

Why?_____, How long?_____

Did parent remain overnight?_____

Habits such as thumb sucking, nail biting, blanket, baby bottle, or favorite toy to bed, etc. of long duration_____

_____

Relationships with others in family_____

Relationships with friends_____

Does child often spend time with grandparent, sitter, etc.?_____

_____

HEALTH: Is child presently under a doctor's care for any illness or condition?_____ If so, please describe:

_____

_____

Is child currently taking medication?_____ If so, please describe_____

_____

Has child had eye exam?_____ hearing exam?_____ dental exam?_____ .

Please state any additional information or specific goals for your child this year on a separate sheet of paper and attach to this.

I GIVE PERMISSION TO KATONAH VILLAGE KIDS TO OBTAIN ANY EMERGENCY TREATMENT FOR MY CHILD IF I CANNOT BE CONTACTED IMMEDIATELY

Signed:_____ DATE:_____