BALDWIN COMMUNITY PRESCHOOL

HISTORY FORM

Today's date_____

Child's name: _____Birth date:_____Sex:____
First Middle Last

Name we should call your child at school: _____

Home address: _____Phone:_____
STREET ZIP

Parent Information:

Mother:

Name:_____ Marital status:_____ Step-Father's name:_____
(If applicable)

Address: _____ Phone:_____
(If different than child's) STREET ZIP

Occupation:_____ Employer's name (If applicable): _____

Would you be willing to share your occupation with the class? _____

Employer's address: _____Phone:_____
STREET ZIP

Father:

Name:_____ Marital status:_____ Step-Mother's name:_____
(If applicable)

Address: _____ Phone:_____
(If different than child's) STREET ZIP

Occupation:_____ Employer's name (If applicable): _____

Would you be willing to share your occupation with the class? _____

Employer's address: _____Phone:_____
STREET ZIP

Siblings of child:

Name:_____Age:____School Grade:___Adopted or stepchild:_____

Name:_____Age:____School Grade:___Adopted or stepchild:_____

Name:_____Age:____School Grade:___Adopted or stepchild:_____

Do they live at home? _____ Weekends? _____ How often? _____

Other members of the household:

Name: _____ Age:___Relationship:_____

Name: _____ Age:___Relationship:_____

Child's Name: _____

Emergency contacts: (Please list three)

Name:_____Phone:_____ Relationship:_____

Name:_____Phone:_____ Relationship:_____

Name:_____Phone:_____ Relationship:_____

Developmental History:

Describe pregnancy (normal, full-term,etc.):_____

_____

Walked at ____months; began talking at ____months; toilet training started at ____ months.

Has child mastered toilet training (y/n)? _____; If Yes, mastered at ____months.

Child used: Bottles? _____ Pacifier?_____ Blanket?_____ Other?_____

Please indicate any that are currently being used_____

Is child adopted?_____Does child know he/she is adopted?_____

Daily Routine:

What time does child get up?_____Bedtime?_____

Nap (y/n)?_____ If Yes, when?_____ Length of nap? _____

Meal Times – Breakfast?_____Lunch?_____ Dinner?_____

Food dislikes?_____ Eating problems?_____

Previous group or school experiences?_____

How did they do in that school? _____

Describe child's neighborhood playmate exposure:_____

Is child right or left handed?_____ Any special fears?_____

Does child cry easily?_____ Display temper tantrums?_____

Some things child loves to do:_____

_____

Some things your child hates to do:_____

_____

Support Services:

Is your child currently receiving Support services? _____

If yes, please check all that apply: Speech _____ OT _____ PT _____

Alliance _____ DART _____ Behavioral _____ Psychologist _____

Wraparound Services _____ Other (Please specify) _____

Any immediate family member with a disability? Physical _____ Mental _____

Comments: _____

Child's Name: _____

Health History:

Date of last doctor visit:_____Last vision screening:_____Last hearing test:_____

Does your child receive recommended vaccinations _____ or exempt? (y/n) _____

Any concerns regarding his/her vision or hearing: _____

Any speech problems? (y/n)_____ Explain:_____

Allergies? (y/n)_____Explain:_____

Physical handicaps? (y/n) _____Explain:_____

Past illness? (y/n) (Please give approximate dates)

Chicken Pox:_____Asthma:_____Rheumatic Fever:_____Hay Fever:_____

Diabetes: _____Rubella:_____Whooping Cough: _____

Other serious illness:_____

Has child ever been hospitalized? _____Explain_____

Please state your evaluation of your child's health:_____

_____

Does child have any problems or situations of which we should be aware? Explain:_____

_____

What method of behavior control is used at home?_____

_____

Child's reaction to method of behavior control?_____

_____

How would you describe your child's personality?_____

_____

Any situation or changes at home of which we should be aware?:

_____

_____

_____

_____

Any other comments:

_____

_____