Bonim Preschool
Congregation
B'nai Israel

INFORMATION SHEET - 2019-2020

Name of Child: _____ Sex:_____Date of Birth: _____/_____/_____

Child's Address: _____

Parent #1 Name: _____ Phone: _____Cell:_____

Address: _____Email:_____

Occupation: _____Business Phone: _____

Employers Name & Address _____

Parent #2 Name:_____Phone: _____Cell:_____

Address: _____Email:_____

Occupation: _____Business Phone: _____

Employers Name & Address:_____

EMERGENCY CONTACT (other than parent)

Name: _____Cell Phone: _____

Name:_____Cell Phone: _____

Physician: _____Phone: _____

Dentist: _____Phone: _____

Other Members of Household (children, relatives, etc.)

Name _____Age _____Date of Birth _____Relationship _____

Name_____Age _____Date of Birth _____Relationship _____

Name_____Age_____Date of Birth _____ Relationship _____

In addition to parents, are there any other caregivers? _____

Persons & Relationship

Name:_____Relationship_____Dates_____

Name:_____Relationship_____Dates_____

Is any language other than English used in the home? _____

Has your child ever been separated for any length of time from his/her parents? _____

How did he/she adjust?_____

Has the family situation changed in the past year? (Death, separation, family, move, birth?)

If yes please explain_____

MEDICAL INFORMATION

Does your child take any medications on a regular basis? _____
If yes, please explain _____
Is your child under doctor's care for any health problems at this time? _____
If yes, please explain _____
Does your child have any dietary restrictions? _____
If yes, please list _____
Does your child have any difficulty with hearing, vision or speech?
If yes, please explain _____
List illnesses your child has had _____
Does your child have frequent colds?_____ Earaches? _____Sore throats? _____

Stomach aches?_____ Fevers?_____

Has your child had any serious accidents or operations? If so, please describe

_____

DAILY ROUTINES

What does your child eat for breakfast? _____
What time does your child go to bed at night? _____Wake up? _____
Does your child have any fears? _____
Does your child have any special attachments (ie. blanket, pacifier, toy, etc.)? _____
If yes, please describe fully_____

_____

Has your child completed toilet learning? _____Urination_____Bowel Movements_____
Can your child indicate his/her need to use the toilet?_____

Does your child need help using the toilet? _____

Does your child sleep in a crib or bed? _____Does your child have difficulty sleeping? _____

If yes, please explain _____

Does your child nap? _____How often?_____Duration?_____

Does your child use a spoon and/or fork? _____ Open cup?_____

Are there any concerns around mealtime or other food related issues? _____

_____

Allergies to food? _____

Medication taken for allergy_____Explain _____

Does your child have any difficulty with elimination or bladder control?_____

Does your child wear diapers or pull ups? _____Night or day?_____

Can your child dress himself/herself?_____ Undress? _____

How is your child encouraged to clean up?_____

GETTTING TO KNOW YOUR CHILD

Please circle items below that describe your child.

Happy	Aggressive	Friendly	Moody	Clumsy
Dependent	Stubborn	Impulsive	Fearful	Quiet
Good-natured	Even-tempered	Attentive	Sympathetic	Shy
Sleepy	Confident	Reserved	Sensitive	

How does your child respond to correction? _____

How does your child separate from each parent or caregiver? _____

_____

What is your child's reaction to new situations? _____

_____

Does your child prefer to play alone or in groups? _____

Does the child have any nervous habits? _____

How does the child handle new situations? _____

Does the child exhibit any definite fears? _____

Does the child anger easily? _____

Does the child exhibit tantrums? _____

What method of discipline do you use? _____

In what particular ways can we help your child this year? _____

_____

When playing with others, with what age children does your child usually play? _____

_____

What are your child's favorite activities? _____

_____

What does your child enjoy doing with each parent _____

_____

What do you hope will be included in your child's class in the year ahead? _____

_____

Goals for your child _____

_____

Strengths of your child _____

_____

What else would you like us to know about your child? _____

_____

_____

***Is your child receiving or ever received any support services from a specialist such as speech, social skills, occupational therapy or physical therapy? If so, please describe. (Please indicate Birth to 3, Board of Education, Private)**

_____

_____

Signature:_____ Date:_____