

**PARK CHILDREN'S DAY SCHOOL  
HISTORICAL RECORD 2015-2016 (for school use only)**

**GENERAL INFORMATION**

Child's Name: \_\_\_\_\_ Name called at home: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Place of Birth: \_\_\_\_\_

Is child adopted? \_\_\_\_\_ Does child know of adoptive status? \_\_\_\_\_

If no, when do parents plan to tell him/her? \_\_\_\_\_

Does child live with both parents? \_\_\_\_\_ If no, what are the arrangements?  
\_\_\_\_\_

Do both parents work? \_\_\_\_\_ What hours? \_\_\_\_\_

Who, besides parents, cares for child? \_\_\_\_\_

Does this person reside in family's home? \_\_\_\_\_

Language(s) spoken at home: \_\_\_\_\_

Does the family go away frequently for weekends? \_\_\_\_\_

Where did parents attend school? \_\_\_\_\_  
\_\_\_\_\_

**CHILD'S HEALTH**

General health since birth? \_\_\_\_\_

Has child ever been hospitalized? \_\_\_\_\_

Any recent illness? \_\_\_\_\_

Allergies? \_\_\_\_\_

Fears? \_\_\_\_\_ Nervous habits? \_\_\_\_\_

Bedtime? \_\_\_\_\_ Usual hours of awakening? \_\_\_\_\_ Naps? \_\_\_\_\_

Eating habits? \_\_\_\_\_ When toilet trained? \_\_\_\_\_

Has your child ever been evaluated? Yes \_\_\_\_\_ No \_\_\_\_\_

Does your child receive Occupational Therapy? Yes \_\_\_\_\_ No \_\_\_\_\_

Physical Therapy? Yes \_\_\_\_\_ No \_\_\_\_\_

Speech Therapy? Yes \_\_\_\_\_ No \_\_\_\_\_

**(OVER)**

**CHILD'S ROUTINE**

Favorite activities? \_\_\_\_\_

Does he/she like to be read to? \_\_\_\_\_  
(favorite books)

Does he/she see other children regularly? \_\_\_\_\_ Where? \_\_\_\_\_

Is he/she able to play alone? \_\_\_\_\_ Happily? \_\_\_\_\_ For how long? \_\_\_\_\_

Where does he/she play indoors? \_\_\_\_\_ Outdoors? \_\_\_\_\_

How much time during the day does he/she spend with each parent? \_\_\_\_\_

With whom does child spend greater part of his/her time? \_\_\_\_\_

What kinds of things do you do together as a family? \_\_\_\_\_

Does the child have his/her own room? \_\_\_\_\_ Shared with? \_\_\_\_\_

Names, birthdates and schools of siblings (if applicable): \_\_\_\_\_

**GROUP EXPERIENCE**

Has the child been a member of a group? \_\_\_\_\_ Where? \_\_\_\_\_

What do you hope the school experience will offer your child? \_\_\_\_\_

If there has been any outstanding event in your child's life in the past few months, such as a new sibling, family move, death of a close relative, serious illness or accident of the child or family member, please specify below. We can work most effectively with your child if we are provided with this important information.

\_\_\_\_\_  
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