NUMCECC CONFIDENTIAL RECORD

Child's name_______________________________________Nickname ______________________

Which name would you like your child to learn to write? _____________________________________

Date of birth__________________   Place of Birth: ______________________________

Parent's Names____

Child lives with: _____Both parents _____Mother _____Father _____Other

Comments: ____

Other members in household:

Name_____________________________________ Age ____ Relationship____________________

Name_____________________________________ Age ____ Relationship____________________

Name_____________________________________ Age ____ Relationship____________________

Is child adopted? ______________________ Does child know? ____________________________

Previous Preschool Experience? ___________ Where _____________________________________

Has anyone other than parents had a substantial role in the rearing of child? _____Yes_____No

If so, who? ____

Do you often use a babysitter? ____

Does your child use any special words for bathroom or elimination? ___________________

Have there, in your family, been any deaths, serious illnesses, or injuries which may have affected your child's attitude, reactions, etc? ____

How does your child react to: other children: ____
(shyly,confidently, with frustration)

To adults outside the family: ____

To new situations: ____

Does your child show preference for right or left hand? ________________________

Does your child have any particular fears or problems? _____________________________

Does your child have pets at home? ____

Does your child have any reactions to animals? _____________________________________

Does your child need help in: Dressing ____________________ Undressing ________________

Washing ____________________ Eating ____________________

What are your child's special interests ____

____

Please fill out other side

Child's Medical History:

Were there any significant problems during pregnancy or childbirth: _____ yes _____ no
If yes please explain

____

____

Was your child more than 3 weeks premature? _____ yes _____ no
If yes, how many weeks premature? _____ Baby's birth weight ___________
Did s/he stay in the hospital longer than his/her mother? _____ yes _____ no
If yes, please explain:

____

____

Has your child ever had a hearing screening? ______ yes _____ no

Results: ____

Has your child ever had a vision screening? ______ yes _____ no

Results: ____

Has your child ever had a dental screening? ______ yes _____ no

Results: ____

Has your child ever had any trouble seeing? ______ yes _____ no

Does your child hold books and other objects close to his/her face? _____ yes _____ no

Do you ever wonder if your child could have any vision problems? _____ yes _____ no
If yes, please explain:

____

Has your child had frequent ear infections or ever had tubes put in his/her ears: _____ yes _____ no

Has your child ever had trouble hearing? _____ yes _____ no

Has your child ever had trouble climbing, reaching, or holding onto things? _____ yes _____ no
If yes, please explain: ____

Does your child have any physical limitations? ____________________________________

Is there anything else you would like us to know about your child?

Parent signature ________________________________ Date ____________________