SOUTHERN BERKSHIRE REGIONAL SCHOOL DISTRICT
PRE-K INTRODUCTORY REPORT

Dear Parent(s)/Guardian(s):

We would like you to help us learn more about your child. The questions below concern your child's everyday behavior and his/her medical history. You know your child best, so your careful answer to each question will be an important help.

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Child's name___________________________________ Date of Birth ____________________

Sex: ☐M ☐F

Address (Mailing) ____

____

(Residence) ____

____

Phone Number ___________________ Work Number ___________________

☐Father's Name __________________________________Occupation ___________________

☐Mother's Name _________________________________Occupation ___________________

(Please specify custody where applicable)____

Brothers and Sister

Name	Date of Birth	School	Grade

Names of other members in the household	Relationship

Language other than English spoken at home: ____

Does anyone else take care of your child on a regular basis? ☐ Yes ☐ No

If yes, who? ____ How often? _________________

Child's experiences

Pre-school experiences____

Early Intervention Service ____
(Pediatrician – CHP-Other referrals)

Has your child been evaluated for special needs? ☐ Yes, ☐ No

Has your family ever worked with the Department of Social Services? ☐ Yes, ☐ No

How did you learn of our program? ____

____

____

Can you provide transportation? ☐ Yes, ☐ No

Do you have specific concerns regarding your child's development? ________________________

____

____

Please check your preference: ☐ NMC (am only)

☐ UME ☐ am ☐ pm

CHILD'S MEDICAL HISTORY

Birth Weight _____________ lbs. __________oz.

Was your baby full term? ☐ Yes ☐ No Premature? ☐ Yes ☐ No

Is your child allergic to any medicines? ☐ Yes ☐ No
If yes, please list them: ____

Does he/she have any other allergies? ☐ Yes ☐ No
If yes, please list them: ____

Has your child ever been seriously ill at home or in the hospital? ☐ Yes ☐ No
If yes, where? ____________________, When? _________________ Why? ________________

Has your child ever had eye treatment or ear treatment? ☐ Yes ☐ No

DEVELOPMENTAL HISTORY

1. Can your child be left alone with a babysitter without a fuss? ☐ Yes ☐ No
2. Does your child have problems with eating? ☐ Yes ☐ No
3. Does your child have problems with sleeping? ☐ Yes ☐ No
4. Is your child highly active? ☐ Yes ☐ No
5. Is your child very quiet? ☐ Yes ☐ No

6. Is your child generally a happy child? ☐ Yes ☐ No
7. Does your child cry very easily? ☐ Yes ☐ No
8. Does your child often have temper tantrums? ☐ Yes ☐ No
9. Does your child usually follow directions? ☐ Yes ☐ No
10. Does your child have a very short attention span? ☐ Yes ☐ No
11. Is your child able to speak most sounds correctly? ☐ Yes ☐ No
12. Do adults easily understand your child? ☐ Yes ☐ No
13. Is your child hesitant to speak with other adults? ☐ Yes ☐ No
14. List your child's favorite playtime activities:
    ☐ T.V. ☐ Video Games ☐ Dolls ☐ Outdoor play ☐ Looking at books ☐ riding a bike

Any other activities: ____

____

15. Exposure to groups such as Day Care, Sunday school, Nursery School?
    Where? ________________________ When? ____________________ How many yrs. ______

16. Does your child have any fears? ☐ Yes ☐ No If yes, please list them:______________________

    ____

17. Is there anything further you wish to mention about your child?

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