

# The Oaks Early Learning Academy

## Personal Information Form

In order to get better acquainted with your child, and to make his/her transition into our program easier – Please answer the following questions. If you are uncomfortable in answering any of these questions, please feel free to leave the information blank.

### Family and Social History:

Name of Child \_\_\_\_\_ Date of Birth \_\_\_\_\_

Child's Nickname \_\_\_\_\_ Sex (M) \_\_\_\_\_ (F) \_\_\_\_\_

Mother's Name (or Guardian) \_\_\_\_\_

Occupation (if employed) \_\_\_\_\_

Father's Name (or Guardian) \_\_\_\_\_

Occupation (if employed) \_\_\_\_\_

E-mail address \_\_\_\_\_

Marital Status of Parents:

Married/Living Together \_\_\_\_\_ Separated \_\_\_\_\_ Divorced \_\_\_\_\_

Remarks (Stepfather, Stepmother etc.) \_\_\_\_\_

Custody/visiting arrangements: \_\_\_\_\_

If Child is Adopted:

Age at Adoption \_\_\_\_\_ Does child know he or she is adopted? \_\_\_\_\_

Brothers and Sisters of Child:

Name \_\_\_\_\_ Grade in School \_\_\_\_\_

Name \_\_\_\_\_ Grade in School \_\_\_\_\_

Name \_\_\_\_\_ Grade in School \_\_\_\_\_

Name \_\_\_\_\_ Grade in School \_\_\_\_\_

Other members of the household (include relationship and age): \_\_\_\_\_

Who has previously cared for your child? \_\_\_\_\_

What previous group experiences has your child had? \_\_\_\_\_

**Developmental History:**

Age at which age did child:

Crept on hands and knees \_\_\_\_\_ Sat alone \_\_\_\_\_ Walked alone \_\_\_\_\_

Name simple objects \_\_\_\_\_ Repeat short sentences \_\_\_\_\_ Slept through the night \_\_\_\_\_

Complete toilet training \_\_\_\_\_

Comments regarding toileting: \_\_\_\_\_

Word child uses for urination \_\_\_\_\_ Bowel movements \_\_\_\_\_

Usual time for B.M. \_\_\_\_\_ Does child dress and undress self? \_\_\_\_\_

Does your child seem to be right or left-handed (or both)? \_\_\_\_\_

What time does the child usually eat breakfast? \_\_\_\_\_ lunch? \_\_\_\_\_ dinner? \_\_\_\_\_

Eating problems or restrictions? \_\_\_\_\_

What time does your child usually: Go to bed at night? \_\_\_\_\_

Get up in the morning? \_\_\_\_\_ Does child sleep well? \_\_\_\_\_

Does your child take a daytime nap or rest? \_\_\_\_\_ How long? \_\_\_\_\_

What are your child's favorite indoor play activities? \_\_\_\_\_

Outdoor play activities? \_\_\_\_\_

Does your child have any special fears that you are aware of? \_\_\_\_\_

Does your child have any speech problems? \_\_\_\_\_

What foreign languages are spoken in the home? \_\_\_\_\_

What method of behavior control is used in your home? \_\_\_\_\_

How would you describe your child's personality? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Health History:**

What illnesses has your child had? At what age?

Chicken Pox \_\_\_\_\_ Scarlet Fever \_\_\_\_\_ Diabetes \_\_\_\_\_ Mumps \_\_\_\_\_ Measles \_\_\_\_\_  
Hepatitis \_\_\_\_\_ Other \_\_\_\_\_

Does your child have frequent illnesses? (Tonsillitis, Earaches, etc.) \_\_\_\_\_

Does your child vomit easily? \_\_\_\_\_

Does your child run high fevers easily? \_\_\_\_\_

Has your child had any serious accidents or illnesses? Explain \_\_\_\_\_

Operations and/or Hospitalization? \_\_\_\_\_

Handicaps? (eyes, ears, feet, etc.) \_\_\_\_\_

Is your child allergic to anything? \_\_\_\_\_ What? \_\_\_\_\_ What symptoms usually occur? \_\_\_\_\_

Asthma \_\_\_\_\_ Hay fever \_\_\_\_\_ Hives \_\_\_\_\_ Other \_\_\_\_\_

Has your child ever: Been to a dentist? \_\_\_\_\_ Had vision tested? \_\_\_\_\_

Hearing tested? \_\_\_\_\_ Worn corrective shoes? \_\_\_\_\_

Comments: \_\_\_\_\_

Is there any information which we should have concerning your child which would help us to understand him/her better? \_\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_\_\_