Child Profile

Original date filled out:	Date reviewed/revised:	Date reviewed/revised:

Student Name:	Date of Birth:
Parent Names:	
Address:	Home Phone:
Email Address:	Cell Phone:
Siblings (names and ages):	
Other significant adults (daycare provider, grandparents, etc…) :	

Student Allergy History

Does your child have allergies or reactions (including intolerances) to food, medicine, insects, animals or other substances?

☐ **NO - Skip to next section** ☐ **YES - Please complete chart below**

Do you keep epinephrine (epi-pen) available at home for your child's allergy? ☐ **NO** ☐ **YES**

List each allergy or food separately	Briefly describe child's reaction	Potential Severe Reaction*	Doctor/Date of Diagnosis
		☐ NO ☐ YES	
		☐ NO ☐ YES	
		☐ NO ☐ YES	

Please include any additional information about allergy:

*If the allergy has the potential to be severe, an emergency plan should be on file at the preschool.

Student Nutrition History

If there is any food or drink that your child should not eat for cultural, religious, personal or medical reasons other than allergies?

☐ **NO - Skip to next section** ☐ **YES - Please complete information below**

Name of food/drink:

Does your child have any problems with chewing or swallowing? ☐ **NO** ☐ **YES**

Please indicate if you have concerns about your child's: ☐ **Eating habits** ☐ **Height** ☐ **Weight**

If you answered yes to any of the above questions, please explain in space below. Please feel free to use another piece of paper if needed.

Student Health History

Were there any significant problems during pregnancy or birth?	☐ **NO**	☐ **YES**
Has your child had surgery or been hospitalized?	☐ **NO**	☐ **YES**
Does your child take medication on a regular basis?	☐ **NO**	☐ **YES**
Name of medication(s), dosage and when taken:		
Has your child had any of the following?		
Asthma	☐ **NO**	☐ **YES**
Other Breathing Problems	☐ **NO**	☐ **YES**
Seizures or other neurological problems	☐ **NO**	☐ **YES**
Heart or other cardiovascular problems	☐ **NO**	☐ **YES**
Bladder or urinary tract problems	☐ **NO**	☐ **YES**
Bowel or other GI problems	☐ **NO**	☐ **YES**
Bone or joint problems	☐ **NO**	☐ **YES**
Eczema or skin problems	☐ **NO**	☐ **YES**
Frequent ear infections or tubes	☐ **NO**	☐ **YES**
Other ear, nose or throat problems	☐ **NO**	☐ **YES**
Tuberculosis exposure	☐ **NO**	☐ **YES**
Diabetes	☐ **NO**	☐ **YES**
Injury or abuse	☐ **NO**	☐ **YES**
If you answered yes to any of these questions, please explain in the space below.		

**Please attach a copy of the doctor's immunization record for your child*

Student Developmental

Do you have any concerns about your child's development in any of the following areas? Has your child's physician referred your child for further assessment, or do they currently receive therapy in any of the following areas? Please indicate by checking boxes below.

Speech	☐ Concerned	☐ Received Dr. Referral	☐ Receiving Therapy	☐ No Concerns
Language	☐ Concerned	☐ Received Dr. Referral	☐ Receiving Therapy	☐ No Concerns
Vision	☐ Concerned	☐ Received Dr. Referral	☐ Receiving Therapy	☐ No Concerns
Hearing	☐ Concerned	☐ Received Dr. Referral	☐ Receiving Therapy	☐ No Concerns
Physical/Motor	☐ Concerned	☐ Received Dr. Referral	☐ Receiving Therapy	☐ No Concerns
Other_____	☐ Concerned	☐ Received Dr. Referral	☐ Receiving Therapy	☐ No Concerns
Other_____	☐ Concerned	☐ Received Dr. Referral	☐ Receiving Therapy	☐ No Concerns

If your child is receiving therapy, are there ways that you or your child's therapist would like the preschool to assist in the treatment? What are your concerns and in what ways do you want the school/teacher to accommodate your child?

Student Information

We embrace children with all learning styles and personalities. In order to help us know and understand your child, please describe his/her temperament (high energy/calm, outgoing/shy, strong-willed/agreeable, set-routine/adaptable, sensory threshold). Are there any situations that have caused him/her difficulty in the past? Are there any development issues that you are aware of?
Please give us a description of your child (their favorite toys, activities and interests, things they particularly don't like to do).
Has your child previously attended preschool or childcare? If so, where and how long?
It is common during the preschool years for children to have fears, and it is very helpful for us to know about them (i.e. loud noises, dogs, use of toilet, separating from caregiver/parent, etc…)
Have there been any significant events (moves, new sibling, medical concerns, divorce, and family tragedy) in your child's life in the last year?
What special interests, projects, family celebrations, cultural traditions, access to special events/materials, ideas, etc. do you want to share with your child's class this year?

Student Information – Continued

If your child's first language is not English, please complete this section.
What language is spoken in your home?
How long has your child been speaking English?
Describe your child's English language abilities:

What do you hope your child will gain developmentally from preschool this year in each of the following areas?
Social
Cognitive/Knowledge
Physical/Motor
Emotional/Spiritual