



St. Matthew's

EPISCOPAL DAY SCHOOL

ABOUT YOUR CHILD

Child's Name _____ Birth Date _____ Sex _____

Address _____ Phone _____

Father's Name _____ Mother's Name _____

Father's Occupation _____ Mother's Occupation _____

Siblings' Name _____ Sex _____ Age _____

Name _____ Sex _____ Age _____

Birth: Normal: _____ Premature: _____ Weight: _____ Complications: _____

Serious illness or hospitalization during the past 12 months? _____ Describe _____

Is child currently taking any long term medication? _____ Describe _____

Does your child have allergies? _____ Describe _____

Previous School Experience _____

What extracurricular activities does your child participate in? _____

EATING HABITS

How many meals each day does your family eat together? _____

How would you describe your child's appetite? _____

What is your child's best meal?

Breakfast? _____ Lunch? _____

Dinner? _____ Snacks? _____

Favorite Foods? _____

BEDTIME HABITS

Awakens? _____ Naps? _____ Goes to bed? _____

Does your child sleep through the night? _____

Does he/she sleep alone? _____ in own bed? _____ in own room? _____

PARENTING

What method of correction is most effective with your child? _____

How do you see yourself in the parenting role? _____

How do you see your spouse in the parenting role? _____

EVERY CHILD IS UNIQUE

What are your child's strengths? _____

With what do you feel your child needs the most help? (e.g. social skills, fine motor, gross motor, speech and language, readiness skills) _____

What are your child's favorite things? _____

What are your child's least favorite things? _____

What is the MOST wonderful thing about your child? _____

Comments: