St. Matthew's
EPISCOPAL DAY SCHOOL

ABOUT YOUR CHILD

Child's Name_____ Birth Date_____ Sex_____

Address_____ Phone_____

Parent 1 Name_____ Parent 2 Name_____
Parent 1 Occupation_____ Parent 2 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:

SUBMIT