

# Village Valley Preschool

## Preschool Admission/ Registration Form

Child's Name \_\_\_\_\_ Birthday \_\_\_\_\_  
Last First Day Month Year

### Personal History

Type of birth:  Normal  Premature; any complications? \_\_\_\_\_  
Does the child:  Crawl? Has the child begun talking?  Yes  No  
Does the child speak:  words?  Walk?  
What language  English  Sentences?  
 Spanish  Other \_\_\_\_\_

### Health

What arrangements can you make for child's care during illnesses?

\_\_\_\_\_  
\_\_\_\_\_

What communicable diseases has your child had?  Measles (Big Red)  Measles (3 day)  
 Mumps  Chicken Pox  Whooping Cough  Other? \_\_\_\_\_  
Any serious illness or hospitalization?  Yes  No: \_\_\_\_\_

Any physical disabilities?  Yes  No: \_\_\_\_\_  
Any known allergies? (Asthma, Hay Fever?)  Yes  No: \_\_\_\_\_  
Are there medications given regularly?  Yes  No: \_\_\_\_\_

### Toilet Habits

Can the child be relied upon to indicate his/her bathroom wishes?  Yes  No  
Does your child frequent toilet accidents?  Yes  No How does your child react to them?

\_\_\_\_\_  
\_\_\_\_\_

### Sleeping Habits

What time does your child go to bed? \_\_\_\_\_ Awaken? \_\_\_\_\_  
What is the child's mood on awakening? \_\_\_\_\_  
Does your child nap?  In the morning?  In the afternoon?  
Give you child's nap schedule \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Social Relationships**

Does your child spend time with both parents?    Yes   No

If parents are separated, how often does your child see the absent parent?

Has your child had experiences in playing with other children?   Yes   No

By nature is your child:    Friendly?   Aggressive?    Shy?   Withdrawn?

Do you feel your child adjusts easily to a child situation?    Yes   No

Does your child enjoy being alone?    Yes   No

How does your child relate to strangers? \_\_\_\_\_

What makes your child angry or upset? \_\_\_\_\_

How does your child show his/her feelings? \_\_\_\_\_

Who does most of the discipline? \_\_\_\_\_

Has your child ever been in a preschool/child care environment?   Yes   No

What was their experience? \_\_\_\_\_

What do you find is the best way of handling your child?

\_\_\_\_\_  
\_\_\_\_\_

Is your child frighten by any of the following:   Animals?   Dark?   Storms?   Loud noises?

Other? \_\_\_\_\_

In what particular way can we help your child? (please use as much space as necessary)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_

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

Parent/Guardian (Print) \_\_\_\_\_