

Zion Lutheran Early Childhood Center

7401 Winkler Road, Fort Myers, FL 33919

239/481-4040

Child's Biographical Data

Child's Name: _____ Birth Date: _____ Sex: M F

1. Why are you sending your child to Zion's Early Childhood Center?

2. How do you expect the Early Childhood Center to benefit your child?

3. Are there any significant personal characteristics of your child that require special handling at the time of and subsequent to admission? Yes: ___ No: ___ If yes, please explain.

Family/Home Background

1. Adults present in the home:

Name	Sex	Birth Date	Relationship (mother, father, aunt, etc)
_____	M F	_____	_____
_____	M F	_____	_____
_____	M F	_____	_____
_____	M F	_____	_____

Are mom and dad both present in the child's primary home? Yes:___ No: ___

If not where is the child's primary Home? _____

2. Other children in child's present home:

Name	Sex	Birth Date	Relationship (brother, step-sister, etc)
_____	M F	_____	_____
_____	M F	_____	_____
_____	M F	_____	_____
_____	M F	_____	_____

Social Development

1. Does your child have children he/she regularly plays with? Yes: ___ No: ___ If yes, please tell us about the environment and ages of the children.

2. Does your child enjoy playing alone? Yes: ___ No: ___ If yes, please describe the types of activities your child most enjoys.

3. Please indicate the types of materials and activities your child enjoys:

<u>Material</u>	<u>No</u> <u>experience</u>	<u>Limited</u> <u>experience</u>	<u>Lots of</u> <u>experience</u>
Playdough	_____	_____	_____
Crayons	_____	_____	_____
Scissors	_____	_____	_____
Paints	_____	_____	_____
Pencils	_____	_____	_____
Markers	_____	_____	_____
Puzzles	_____	_____	_____
Blocks	_____	_____	_____
Paste/Glue	_____	_____	_____
Dolls	_____	_____	_____
Dress-up	_____	_____	_____
Water	_____	_____	_____
Sand	_____	_____	_____
Games	_____	_____	_____
Computers	_____	_____	_____
Dancing	_____	_____	_____

Below, please list additional materials and activities your child might enjoy:

4. Does he/she watch T.V. regularly? Yes: ___ No: ___ if yes, what types of shows does he enjoy?

5. Does he/she enjoy stories? Yes: ___ No: ___ if yes, please list some of her favorites.

6. Does he/she enjoy music? Yes: ___ No: ___ if yes, please list some of his favorites.

7. Please explain his/her relationship with his/her brothers and/or sisters.

8. Has your child had any kind of experience with a supervised group? Yes: ____ No: ____ if yes, please explain.

Physical Development

1. Was your child born prematurely? Yes: ____ No: ____ if yes, please explain circumstances including number of weeks premature.

2. Was your child early ____ average ____ late ____ in walking?

3. Was your child early ____ average ____ late ____ in talking?

4. Check any of the following areas where you have a concern regarding your child:

____ Thumb sucking ____ Elimination ____ Bed Wetting

____ Hearing ____ Nervousness ____ Speech

____ Other- Please specify: _____

5. Are there any physical conditions special to your child? Yes: ____ No: ____ if yes, please explain.

Cognitive Development

1. Does your child recognize colors? Yes: ____ No: ____

2. Does your child count? Yes: ____ No: ____ if yes, to what number? _____

3. Does your child recognize his/her name? Yes: ____ No: ____

Can he spell it? Yes: ____ No: ____ Can she write it? Yes: ____ No: ____

4. Does your child recognize uppercase letters? None: ____ Some: ____ All: ____

5. Does your child recognize lowercase letters? None: ____ Some: ____ All: ____

Emotional Development

1. How does your child react to new situations?

2. How does your child react to strangers?

3. Listed below are situations which your child Might find frightening. Please rate the degree of fear you think your child might feel for each with the following scale:

1- Very Fearful 2- Moderately Fearful 3- Slightly Fearful 4- Not At All Fearful

Darkness _____ Being Alone _____ Storms _____ Animals _____

Other (Please list) _____

4. How does your child react to any of the above situations when frightened?

5. How would you recommend that your child be comforted here at school should he/she become frightened?

6. How do you think your child feels about coming to school here at Zion?

7. Does your child have a special object they use for comfort such as a blanket, thumb, or animal?
Yes: ____ No: ____ if yes, please list his favorite(s).

Will your child bring this object to school? Yes: ____ No: ____

What are your feelings concerning your child's use of a security object?

8. How does your child typically deal with frustration? (Check all that apply)
 Becomes Aggressive Cry Hide
 Openly Discusses Frustration Become Withdrawn
 Other – Please describe:

9. Who does your child rely on to deal with frustrations? (Check all that apply)
 Self Mom Dad Peers Sibling
 Others – Please specify:

10. How would you describe your child's self-confidence?

Discipline

1. How is your child disciplined while at home?

2. Are you comfortable with the discipline method you are currently using?

3. Do you find this method to be beneficial for your child?

4. Describe your child's reaction to the style of discipline used at home.

5. How would you recommend your child be disciplined where here at school?

Other Areas

1. Is your child taking any medication? Yes: ____ No: ____ if yes, please explain.

2. Does your child have any allergies? Yes: ____ No: ____ if yes, please explain.

3. Does your child have any medical issues that you feel we should be aware of, such as asthma, skin conditions, or diabetes? Yes: ____ No: ____ if yes, please explain.

4. Is your child on a special diet, either food or beverage? Yes: ____ No: ____ if yes, please describe indicating the reasons for the restrictions.

5. Does your child have any emotional, physical, and/or learning disabilities? Yes: ____ No: ____ if yes, please explain and include any information concerning the disability, such as test results, with this form.

Has your child seen a specialist for any of the above disabilities? Yes: ____ No: ____ if yes, it would be helpful for us to contact the specialist(s) involved to better serve your child. Therefore, please list contact information (name, address, and phone) of each specialist.

Is your child currently taking any medication for the disabilities listed? Yes: ____ No: ____ if yes, please list.

Thank you for taking the time to share this information about your child. We will use it to make your child's transition into our program as comfortable as possible.

Parent/Legal Guardian Signature

Date Signed