STUDENT INFORMATION FORM

Date:______________

Child's Name: __________________________________ Nickname:__________

Date of Birth: __________________ Age: _____ Level:____________ Sex: M ___ F ___

Religion: ____________ Nationality:_____________ Language/Dialects Spoken: _____________

Home Address: ____

Home Phone: ____________________ School Last Attended: ____________________________

Existing medical conditions (allergies, congenital conditions, special needs, etc.)

____

Family Information:

Mother's Name: ___________________________ Nickname: _____________

Occupation: _________________ Contact No(s): _______________________

Email Address:__________________________________

Office Address: ____

Father's Name: ___________________________ Nickname: _____________

Occupation: _________________ Contact No(s): _______________________

Email Address:__________________________________

Office Address: ____

Sibling Information:

Name:	Age	Sex	Grade Level	School

Emergency Contact List:

Doctor: ______________________________ Phone: _________________________

Hospital Preference: _______________________

Parent/guardian: _____________________ Phone: _________________________

Student Questionnaire

1. Which tasks can your child do independently: (please check)

   ___ using the toilet ____ eating ___ hand washing ____drinking

   ___ dressing up ____ undressing ___ packing away

2. What is your child's current family structure? (Nuclear, Single parent, living with extended family, etc.)

   ____

3. Does your child have an established routine at home? If so, please explain.

____

4. What activity does your child enjoy the most? Which activity does he/she like the least?

____

5. What incidences commonly causes your child's outburst or tantrums?_________________________________

6. Who does your child spend most of his/her time during the day?

   ____

7. What discipline strategies do you use on your child?

   ____

8. When playing with other kids, what role does your child assume? (initiator, follower, parallel play, etc.)

   ____

   Please describe your child: ______________________________

9. Describe your child's attitude towards using art & writing materials (painting, scribbling & coloring)

   ____

10. How does your child react to unfamiliar materials? (e.g. clay, slime, mud)

    ____

11. Describe how your child communicate his/her needs.

    ____

12. What are your child's current interests? (Favorite toy, friend, game, activity, food etc.)

    ____

13. Tell us about your child's Math Skills (numbers, colors, shapes)

    ____

14. Does your child enjoy reading?

____

15. Tell us about your child's Literacy Skills.

____

16. Does your child have any special fear?

____

17. Does your child dislike any particular food?

____

18. Does your child attend any special programs/therapies?

____

19. Does your child require any special medical care?

____

Medical History: (Please check is applicable)

	YES	NO		YES	NO
Bronchitis			Primary Complex		
Whooping Cough			Dengue		
Rubella			Vision Impairment		
Chicken Pox			Hearing Impairment		
Mumps			Eye Infection		
Measles			Ear Infection		
High Fever/Convulsions			Speech Delays		

_________________________________ ____________________

Parent's Signature over Printed Name Date