Student Activity/Behavior Information

Child's Name _____Birth Date _____

What time does your child go to bed at night? _____Wake Up? _____

What does your child usually eat for breakfast? _____

Does your child have any fears? _____

Does your child play well alone? _____In groups? _____

Does your child have neighborhood playmates? _____

With what age children does your child usually play? (Same, older, younger) _____

Does your child accept correction easily? _____

What is the method of behavior control do you use in your home?

_____

_____

_____

Please circle the items below that describe your child:

Happy	Aggressive	Friendly	Moody	Clumsy
Dependent	Stubborn	Impulsive	Fearful	Quiet
Good Natured	Even-Tempered	Attentive	Sympathetic	Shy
Sleepy	Other:			

Do you have any concerns about any aspect of your child's development?

_____

_____

Is any language other than English used in the home? If so, explain:

_____

Does your child frequently suffer from any of the following? (Please Circle)

If so, please list how often?

Colds Ear Infections Stomachaches Fevers Sore Throat

_____

_____

_____

Has your child had any serious accidents or operations? If so, please explain...

_____

_____

_____

Are there any special medical, physical, or emotional needs that the staff should be aware of?

_____

_____

_____

What are your child's favorite activities?

_____

_____

_____