

**INTRODUCE US TO YOUR CHILD**  
**St. Luke's Day School**  
**School Year: \_\_\_\_\_**

Please note that this information is for the **confidential use** of the teachers who will be working with your child. The more completely you answer the questions, the better they will be able to understand your child.

Child's Full Name \_\_\_\_\_ Name Called \_\_\_\_\_  
 Home Address \_\_\_\_\_ Zip \_\_\_\_\_ Primary Phone \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ Gender Male Female

Mother's Name (include maiden name) \_\_\_\_\_  
 Place of Employment \_\_\_\_\_ Work Phone \_\_\_\_\_  
 Profession \_\_\_\_\_

Father's Name \_\_\_\_\_  
 Place of Employment \_\_\_\_\_ Work Phone \_\_\_\_\_  
 Profession \_\_\_\_\_

**Marital Status:** Married Partnered Separated Divorced Widowed  
**Child Lives With:** Both Parents Mother Only Mother & Stepfather Guardian  
 Father Only Father & Stepmother Joint Custody

Custody/Visiting Arrangements \_\_\_\_\_

Remarks \_\_\_\_\_

**If Child Is Adopted** (optional)

Age at Adoption \_\_\_\_\_ Does child know he/she is adopted? Yes No

Remarks \_\_\_\_\_

**Family Culture** (optional)

Ethnicity: \_\_\_\_\_ Religion: \_\_\_\_\_

Home Language(s): \_\_\_\_\_

**Health History**

**Allergies:** Yes No (if yes, please be very specific below) **Asthma:** Yes No

Type: Food Insect Bite/Sting Seasonal Medication Other

Allergic to: \_\_\_\_\_

How does the reaction manifest itself? \_\_\_\_\_

How should the reaction be treated? \_\_\_\_\_

**General Health Information:**

Does your child have any dietary restrictions?      Yes      No

If yes, please explain

Has your child had any serious illness, injury, or hospitalization during the last year?      Yes      No

If yes, please explain

Check if you have any concerns about:      Speech (articulation)      Vision      Language      Hearing  
Physical Development      Social Development

If so, please explain

Does your child have any diagnosed special needs\*?      Yes      No

(\*i.e., speech, language, hearing, developmental delay, physical, emotional, behavioral)

If yes, please explain

Is your child in any kind of therapy?      Yes      No

Remarks:

If yes, type:      Occupational      Speech/Language      Physical      Social Skills/Behavioral

If yes, Therapist’s Name      Therapist’s Phone

I give permission for the teacher to discuss my child’s therapy with therapist listed above.      Yes      No

**For children enrolled in Infant/Toddler or Twos classes, please answer the following:**

At time of delivery, was your child:      Full-term      Premature      Overdue

Were there any complications during pregnancy?

Age at which child: Crawled      Sat Alone      Walked      Named Simple Objects

Does your child use a pacifier?      Yes      No

If yes, when?

Are you currently nursing your child?      Yes      No

Does your child drink from:      Bottle      Sippy Cup      Cup

Is there any special information about your child’s eating, sleeping or diapering that we should know?

Is there a special blanket or toy needed at naptime?      Yes      No

If yes, please describe

**For children enrolled in Twos, Threes, Pre-K or Kindergarten classes, please answer the following:**

Does your child nap?      Yes      No

Is your child right or left handed?      Right      Left      Undetermined

Does your child have any special fears?      Yes      No      If yes, how are you dealing with them?

Has your child had vision or hearing testing?      Yes      No

Remarks:

**General Information—please answer for all children:**

What causes your child to show his/her temper?

How is temper displayed?

What method of behavior guidance is used in your home?

Please list the names of all children (include age and school) and adults living in the home, and state relationship to the child:

Does your child follow a daily routine?      Yes      No

How does your child react to a change in routine?

During the school year, is there a baby due?      Is a move planned?

What pets do you have in your home?

Has your child had experience in a playgroup?

Has your child previously attended preschool?      Yes      No

If both parents are away from home during the day, please state arrangements for child's care when not at school:

Have there been any family experiences that have influenced your child, such as a move, serious illness, extended guests in your home, or travel?

Do you have any other concerns that we should be aware of?

How would you describe your child's temperament (easy going, slow to warm, etc)?

If you wish, use this last page to tell us more about your child. Include any information that would be helpful to your child's teacher.

Parent's Signature

Date