EMERSON ACADEMY

early education for all abilities

Registration Information Questionnaire

Date _____

Child's Name _____
(First) (Middle) (Last)

Date of Birth ____/____/_____ Age (as of Sept. 1st)_____ Sex _____

Place of Birth _____ Home School (District)_____

Language/s Spoken in the Home _____

Does your child have siblings? Yes No

If yes, please list their name(s) and dates of birth:

_____

_____

Living Situation: Please describe any custodial situations, as well as who lives in the home with your child:_____

_____

_____

SOCIAL HISTORY

Has your child ever attended a childcare center? Yes No

If yes, where? _____

Does your child receive Early Childhood Intervention (ECI) services or Special Education through the school district? Yes No

If yes, where? _____

What are your child's most enjoyable activities?

_____

_____

What things frighten your child? _____

_____

What do you do to comfort your child? _____

_____

How does your child communicate his/her needs?_____

_____

What is your child's sleeping/napping schedule and preferences?_____

_____

_____

What are your child's favorite activities and toys?

_____

_____

_____

List the places your child frequently visits: _____

_____

List the significant people in your child's life: _____

_____

_____

List significant holidays and/or cultural celebrations that your child participates in:

_____

_____

_____

List religious/cultural information that you'd like to share with your child's teacher:

_____

_____

Is there anything that you would like for Emerson Academy staff to know about your background or beliefs that you believe will help us to understand your family better? If so, please list any information, special requirements or requests below:

_____

_____

_____

_____

DEVELOPMENTAL MILESTONES

When did your child first: (mark n/a if not yet reached)

Smile _____Roll over_____ Babble _____ Say first word _____

Combine two words _____ Sleep through the night _____

Sit up_____ Crawl on hands and knees _____ Stand Alone _____

Take first step _____Toilet train_____ Toilet train for sleep _____

if not toilet trained, please describe toileting behavior: _____

_____

Comments / Concerns regarding developmental milestones:

_____

_____

_____

_____

MEDICAL INFORMATION

During pregnancy, did mother experience any unusual illnesses, conditions, or accidents? Yes No If yes, please describe: _____

Length of pregnancy _____ Complications during delivery? Yes No

If yes, please describe: _____

Birth Weight _____lbs. _____oz.

Did the baby have trouble breathing? Yes No

If yes, please describe: _____

Did the baby have feeding problems? _____

Was the baby on a respirator? _____

Did the baby have seizures? _____

Were there any other problems? _____

Check the illnesses the child has had, if any. Pleas indicate the child's age at the last occurrence, and whether or not the child was hospitalized:

Illness	Yes	No	Age	Hospitalization
Measles	_____	_____	_____	_____
Chicken Pox	_____	_____	_____	_____
Mumps	_____	_____	_____	_____
Strep Throat	_____	_____	_____	_____
Scarlet Fever	_____	_____	_____	_____
Tonsillitis	_____	_____	_____	_____
Ear Infections	_____	_____	_____	_____
Seizures	_____	_____	_____	_____
Meningitis	_____	_____	_____	_____

Were any of these illnesses followed by noticeable changes in the child's general behavior? Yes No

If yes, please describe:_____

_____

Describe any surgeries the child has had: (Surgery Date, Hospital)

_____

_____

Does your child have allergies? Yes No

If yes, please list:

_____

_____

List medications that your child may take on a regular basis (Medication, Dosage, Reason taking):_____

_____

Please list the names of your child's doctor(s) and his/her contact information:

_____

_____

_____

Vision (Screening required for four (4) year olds)

Does your child have a vision problem? Yes No

If yes, please describe: _____

Date of most recent vision test: _____Test results:_____

Place tested completed: _____

Hearing (Screening required for four (4) year olds)

Does your child have a hearing problem? Yes No

If yes, please describe: _____

Date of most recent hearing test: _____Test results:_____

Place tested completed: _____

Developmental Evaluation

Has your child been diagnosed with any developmental problems? Yes No

If yes, please describe: _____

Date of most recent developmental evaluation: _____

Evaluation results: _____

Place evaluation was completed: _____

Therapy Services

List the therapy services (if any) your child has received:

Type of therapy: _____ Dates: _____

Therapist: _____ Location: _____

Your child's reaction to the therapy (positive and negative): _____

_____

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Therapist: _____ Location: _____

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_____

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_____