



Child Information

Please take a few minutes to answer the questions below. The questions will help your child's teacher better understand your child's needs within the classroom. Thank You!

Child's Name: _____

Parents Names: _____

Parents primary Contact Phone: _____

Health Information:

Life-Threatening Allergies: YES / NO

If yes, please specify: _____

Does your child have an EPIPEN? YES / NO

Does your child have asthma or any other medical conditions? YES / NO

If yes, please explain in detail:

Do you have concerns about their development? YES / NO

Please give details on concerns:

Speech and Language:

Language child speaks at home: _____

Language parents use most often at home: _____

- | | |
|---|----------|
| 1. My child can say their first name. | YES / NO |
| 2. People other than parents can understand my child's speech. | YES / NO |
| 3. My child can verbalize their needs when hungry, thirsty, bathroom, etc | YES / NO |
| 4. Does your child exhibit a delay in speech? | YES / NO |

If yes, please share more details: _____



Social Emotional:

- | | |
|---|----------|
| 1. My child plays well with other children. | YES / NO |
| 2. My child uses toys safely and appropriately. | YES / NO |
| 3. My child makes eye contact when interacting with adults and children | YES / NO |
| 4. My child likes to sit and read books. | YES / NO |

Any other information you would like to share:

Parents Signature: _____

Date: _____
