

Preschool Application Form

I. Identifying Information

Child's Name _____ Nickname _____ Age _____ Birth date _____ M / F

Child's Home Address _____
Street City State Zip

Name of Parent/Guardian _____ Name of Parent/Guardian _____

Relationship to child _____ Relationship to child _____

Address (if different than above): _____ Address (if different than above): _____

Occupation _____ Occupation _____

Phone: Home (____) _____ Phone: Home (____) _____

Work or Cell (____) _____ Work or Cell (____) _____

Are languages other than English (including sign language) used at home? _____yes _____no

If Yes, what language (s)? _____

II. Referral

How did you hear about our program? _____

Do you have concerns about your child's speech and language development? _____yes _____no

If yes, please explain here: _____

Is/Has your child received speech/language and/or developmental services? _____yes _____no

If yes, please note type of therapy, the therapist and contact info here:

What do you hope your child will gain from the program? _____ language stimulation _____ learn more English
_____socializing with peers _____ a general preschool experience _____ to correct speech & language problem

III. Communication Skills

What does your child use the **most**? _____ complete sentences _____ phrases _____ one or two words
_____ sounds _____ gestures _____ physically takes adult to item _____ augmentative communication system

At what age did you child say his/her first word? _____ What were the child’s first few words?

Approximately how many words did your child have at... 18 months? _____ 24 months? _____

At what age did your child say his/her first sentence? _____ Give some examples of first sentences:

Give an example of typical sentences the child currently uses:

Estimate the percentage of time that your child is understood by:

_____ parents _____ other adults _____ brothers and sisters _____ friends

Please indicate your child’s level of understanding of other’s by checking those that apply:

_____ understands gestures _____ does **not** understand spoken words _____ understands single words
_____ understands simple sentences _____ understands 2 and 3 part commands _____ understands conversation

IV. Hearing

Yes No

____ ____ Do you feel your child hears well?
____ ____ Has your child ever had an ear infection? If so, which ear? _____
Last occurrence _____ First occurrence _____ Frequency _____
____ ____ Does he/she presently have or is the past had draining ears?
____ ____ Does he/she wear hearing aids? If Yes: Make and model _____ since _____
____ ____ Has your child ever had a hearing test? If yes, when? _____ Results? _____

V. Prenatal (pregnancy) and Birth

Mother’s date of birth _____ Father’s date of birth _____

Length of Pregnancy in weeks _____

Explain any complications during pregnancy:

Did you have a normal delivery with this child? _____ yes _____ no If no, please explain:

Were there any problems or complications immediately following birth or during the first two weeks of your infant’s life? (feeding, seizures, sleeping, swallowing, hospitalizations, etc.):

VI. Development

In your opinion, is your child **typical** for his/her age in:

Self Help Skills

Eating yes___no___

Toileting yes___no___

Dressing yes___no___

Social Skills

playing with peers yes___no___

general social interactions yes___no___

Please explain any areas checked as "no"

For toileting, what kind of help and/or what words or gestures will your child be using?

In your opinion, is your child **typical** for his/her age in:

Large muscle skills

Walking yes___no___

Running yes___no___

Jumping yes___no___

Going up stairs yes___no___

Throwing/catching a ball yes___no___

Small muscle skills

coloring yes___no___

cutting yes___no___

building with blocks yes___no___

Please explain any areas checked as "no":

Would you describe your child's coordination as: ___good ___fair ___poor?

VII. Medical History

Name of child's Pediatrician/Doctor _____ Phone: _____

Address _____

Street

city

state zip

List any past or current health problems your child has:

Does your child have allergies (including food)? ___yes ___no If yes, please elaborate:

Is your child currently on medication? ___yes ___no If yes, please explain:

Do you have any concerns about your child's eyesight? ___yes ___no If yes, please explain:

VIII. Cognitive History

Has your child ever had a neurological or multidisciplinary team evaluation? ___yes ___no

Any other relevant evaluations? ___yes ___no

Please provide us with a copy of any evaluation reports you may have.

IX. Home and Family

Please list siblings and other members of the household (not listed on page 1) :

Name	Date of birth	Age	M/F	Relationship to child
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Do any of the above individuals have speech, language or hearing problems? ____yes ____no

If yes, please explain:

Are there any other family members (grandparents, cousins, etc) that have a hearing loss or communication problem? ____yes ____no If yes, please explain:

X. Day Care and School Experiences

Does your child attend: ____daycare ____preschool ____other?

Name of daycare or school _____

When is he/she in the daycare or preschool program? _____

How does your child relate to children in their age group? _____

Other programs your child has attended:

XI. Preschool Teacher's Questions

How would you describe your child? Reserved? Confident? Assertive? Etc.

How does your child react when he/she is upset or sad? What is the best way to comfort him/her?

How does your child deal with frustration? What strategies do you employ?

How does your child deal with separation?

List a few of your child's favorite activities:

Does your child have any pets? (Real or favorite stuffed animal ☺)