



CHILD INFORMATION FORM:

Child's Name: _____

Parent(s) Name(s): _____

Please circle: 3 Year Program 4 Year Program

1. What would you like your child to get out of our preschool program? What are your objectives for your child?

2. Has your child had any other previous preschool group experiences?

Yes _____ No _____

If yes, could you tell us a little bit about it?

3. Is your child comfortable with being away from you for short periods of time?

4. Can you tell us a little bit about your child and his/her special interests?

5. What makes your child uncomfortable? Does your child have any particular fears or anxieties?

6. How does your child adapt to and adjust to new or unfamiliar situations?

7. Are your child's immunizations up to date?

Yes _____ No _____



8. Has your child had any Childhood Illnesses that we should be aware of?

9. Does your child have a health problem that could interfere with or prevent full activity?

Yes _____ No _____

If yes, what is the health problem?

10. Does your child have any allergies? Please list and complete the attached Allergy Protocol Form if there are any.

11. Does your child have a speech problem? Yes No
If yes, is your child receiving speech therapy? Yes No

12. Does your child have a history of hearing problems? Yes No
If so, what is the problem? _____

13. Does your child have a history of intermittent ear infections? Yes No

14. Does your child have a history of vision problems? Yes No
If yes, what is the problem? _____

15. Is your child on long-term medication? Yes No
If yes, what is the name of the medication? _____

16. Has your child ever been hospitalized? Yes No
If yes, for what reason? _____

17. Is there any other information regarding your child that you wish to share that would be helpful for the teacher? Please comment here or on the back of this form if more space is required.

18. Is your child currently taking any medication? YES or NO

If yes, please fill out the attached authorization to administer medication form.

***Note, you must complete one form for each medication your child may be required to take.



It would be helpful to inform the teacher of situations which may affect your child as they arise during the school year (i.e., births, deaths, separation, illnesses, divorce, etc.) Please notify the teacher if there is any change in the health, medications, dosage, or time medication is given. All information will be treated confidentially.



ALLERGY PROTOCOL

(To Be Completed Only if Child Has Allergies)

CALL 911 If In Respiratory Distress

Child's Name:		
Parents Names:		
Allergies (Please List All, if none, list none)	Reaction	Treatment
Primary Emergency Contact (name & number):		
Child's DOB:	Child's Alberta Health Number:	Child's Family Doctor (name & number):



AUTHORIZATION TO ADMINISTER MEDICATION

I, _____, hereby authorize and instruct Scarboro Community
(print name of parent/guardian)
Preschool, to administer _____
(print name of student) (print name of medication)

_____ At _____ on _____
(amount or dosage) (times to be given) (actual date: first and last)

As prescribed by _____ and dispensed under
(name of doctor including initial)

Prescription number _____ (this number must match the label).

I understand that the medication must be in the original container and properly labeled with the student's names, date of issue, name of prescribing physician, dosage, and instructions. Staff will keep a daily record of medication(s) administered.

Date

Signature of parent or guardian

Name (printed)