Family Questionnaire

Student Name: ____

Date of Birth: __________________________ Today's Date: ___________________

In order to get to know your child better we ask that you fill out this form and return it with your application.

General Information

Primary language spoken at home: ____

Mother's Occupation: ____
How many hours per day does mom work? ___________
How often is mom out of town? ___________________________________
Father's Occupation: ____
How many hours per day does dad work? ____________
How often is dad out of town? ____________________________________

Health Information

Was your child adopted? Yes No
Did the pregnancy go to full term? Yes No
Were there any complications with your pregnancy? Yes No
If so, what kind? ____

What illnesses has your child had (ear infections, etc.)? __________________________________
____
Highest fever? _________ How long did it last? __________________________
Does your child have any allergies? Yes No If yes, what kind? ________________________
Does the allergy require maintaining an EPI Pen or other medication at school? Yes No
Does your child have a medical condition that requires immediate access to medication or a specific response from staff? Yes No If so, what are they? _______________________________________
Is your child sun sensitive? Yes No
How old was your child when he/she started walking? ______________________
Age when first word was spoken? _____________________________________
Is your child taking any daily medications? Yes No
If so, what kind? ____
Does your child have any special needs that we should be aware of? Yes No
If yes, please explain: ____
____
Does your child have any vision or hearing problems? Yes No
If so, please explain: ____

Family and Childcare Information

Does your child have any siblings? Yes No
Name: ___________________ Age: ________ Describe relationship: ___________________________
Name: ___________________ Age: ________ Describe relationship: ___________________________
Name: ___________________ Age: ________ Describe relationship: ___________________________

Parents' marital status: ________________________
With whom does your child live? ____________________________________

What does your child enjoy doing most? ____
What activities does your family enjoy doing together? _______________________________
Does your child prefer to play alone or with playmates? ______________________________
When playing with playmates, how does your child react to conflict (words, crying, hitting, passive, etc.)?
____
____

Describe any other school or group situation in which your child has participated and for how long.
Age: _____ Name of School __________________ Describe: __________________________
Age: _____ Name of School __________________ Describe: __________________________

Which situation did your child like most and why? ___________________________________
____

Please describe, if any, difficulties that your child may have had in another school or group setting?
____
____

Routines (It would help us to have an idea of your child's typical day)

Are meals at a set time? Yes No Where are meals eaten? ________________________
Are meals with adults? Yes No Does your child sit in a high chair/booster chair? Yes No
What time does your child go to bed? ________ What time does your child wake up? __________
Does your child sleep through the night? Yes No
Is your child prone to nightmares? Yes No
Does your child have his own room? Yes No Does your child sleep alone? Yes No

In what ways do you encourage independence in your child? ___________________________
____

On average, how many hours of TV does your child watch per day? _____________________

Are you aware that Montessori is based on a 3 year cycle? Yes No
What brought you to Arcadia Montessori School? ____________________________________
____

What are your goals for your child this year? ____
____