

Student's Information Sheet

Date: _____

Name of Student: _____ Age by June: _____
Years & Months

Entering Level: _____

I. SCHOOL HISTORY

<u>Name of School/s Attended</u>	<u>Level</u>	<u>Length of Time</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

II. HOME ENVIRONMENT

List all the people that live with the child at home.

<u>Name</u>	<u>Relationship to Child</u>
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

When the child is home, what does he/she like to do? What are his/her favorite activities?

Are there routines that the child follows regularly? If yes, what are they?

Who usually follows-up on these routines? _____

What are the child's favourite food? _____

Can he/she eat by him/herself? _____

Describe his/her appetite and how he/she eats? (e.g. eats anything, picky, affected by moods, slow, etc.)

Is the child toilet-trained? _____

Can the child dress-up by him/herself? _____

What other self-help skills is he/she capable of?

What are the house rules regarding the following?:

Meal times? _____

Study periods? _____

TV viewing schedule? _____

Computer or other electronic gadget schedule? _____

Junk food? _____

Toys? _____

How are these rules explained to the child?

III. HEALTH

Please check the appropriate line. Kindly report any incidence since birth.

Eyes

Has your child had any trouble seeing? Yes ___ No ___ I don't know ___

Have your child's eyes ever looked crossed? Yes ___ No ___ I don't know ___

Ears

Has your child ever had frequent ear infections? Yes ___ No ___ I don't know ___

Has your child had any trouble hearing? Yes ___ No ___ I don't know ___

Neurological

Has your child had fainting or blackout spells? Yes ___ No ___ I don't know ___

frequent headaches? Yes ___ No ___ I don't know ___

dizzy spells? Yes ___ No ___ I don't know ___

fits or convulsions? Yes ___ No ___ I don't know ___

Allergies

Please check the appropriate boxes. Write specifications on the blank beside each box.

My child is allergic to:

Seafood _____

Nuts _____

Fruits _____

Eggs _____

Dairy _____

Chocolates _____

Dust, Pollen, etc. _____

Insect Bite _____

Others _____

My child has no allergies.

Medications

Please give my child the following medications for the following situations:

Fever: _____

Dosage: _____

Stomachache: _____

Dosage: _____

Headache: _____

Dosage: _____

Toothache: _____

Dosage: _____

Minor cuts or wound: _____

Minor rash: _____

IV. LANGUAGE DEVELOPMENT LEVEL

What language/s is/are used at home? _____

What language is your child most comfortable with? _____

What language does your child use to communicate with the following?:

Parents? _____

Siblings? _____

Househelp? _____

Other relatives? _____

When your child communicates, is he/she understood by everyone? If no, why not?

V. SOCIAL MATURITY

Relationship with Peers

Whom does your child play with at home? _____

Outside of the home? _____

Please check the line appropriate line.

➤ How is your child with his/her siblings? _____ dominant _____ a follower

_____ gregarious _____ aggressive _____ cooperative _____ generous

_____ selfish _____ helpful _____ others: _____

➤ With friends? _____ dominant _____ a follower _____ gregarious

_____ aggressive _____ cooperative _____ generous _____ selfish

_____ helpful _____ others: _____

➤ With relatives of the same age group? _____ dominant _____ a follower

_____ gregarious _____ aggressive _____ cooperative _____ generous

_____ selfish _____ helpful _____ others: _____

➤ With other children of the same age group? _____ dominant _____ a follower

_____ gregarious _____ aggressive _____ cooperative _____ generous

_____ selfish _____ helpful _____ others: _____

Relationship with adults

➤ How is your child with you his/her parents? _____ timid _____ attached

_____ docile _____ trusting _____ confident _____ manipulative

_____disobedient _____ others: _____

➤ With other significant adults – grandparents? _____ timid _____ attached

_____ docile _____ trusting _____ confident _____ manipulative

_____disobedient _____ others: _____

➤ Yaya or nanny? _____ timid _____ attached _____ docile _____ trusting

_____ confident _____ manipulative _____disobedient

_____ others: _____

➤ Aunts and uncles? _____ timid _____ attached _____ docile

_____ trusting _____ confident _____ manipulative _____disobedient

_____ others: _____

➤ Other people of authority? _____ timid _____ attached _____ docile

_____ trusting _____ confident _____ manipulative _____disobedient

_____ others: _____

VI. EMOTIONAL MATURITY

What is your child's general disposition? Is he/she jolly, moody, daring, confident, etc.?

How does your child react to rules and regulations at home? Does he/she follow immediately, need to be reminded a few more times before following or insists on what he/she wants?

In relation to work, how does your child react to simple jobs or responsibilities assigned to him at home? Is he/she able to do more than expected, what is expected or refuses to work his tasks at home?

How does your child react to difficulties and disappointments? Is he/she flexible or easily discouraged?

VII. SPECIAL INTERESTS

What are the hobbies of your child? Does he/she take particular interest in books, music, games, etc.?

Is your child enrolled in any special classes like ballet, taekwondo, swimming, piano lessons, gymnastics, etc.?

VIII. OTHER IMPORTANT INFORMATION

Name of Person to contact in case of emergency: _____

Relationship with Child: _____

Contact Numbers: _____

Name of your child's paediatrician: _____

Contact Numbers: _____

Hospital Affiliations: _____

Who will be taking your child to school and back home from school?

Please check the appropriate boxes.

My child is afraid of:

Party Mascots

Sound of Thunder

Sound of Heavy Rain

Animals _____

Others _____

Other information, necessary for the school to know:

Father's Signature over Printed Name

Mother's Signature over Printed Name