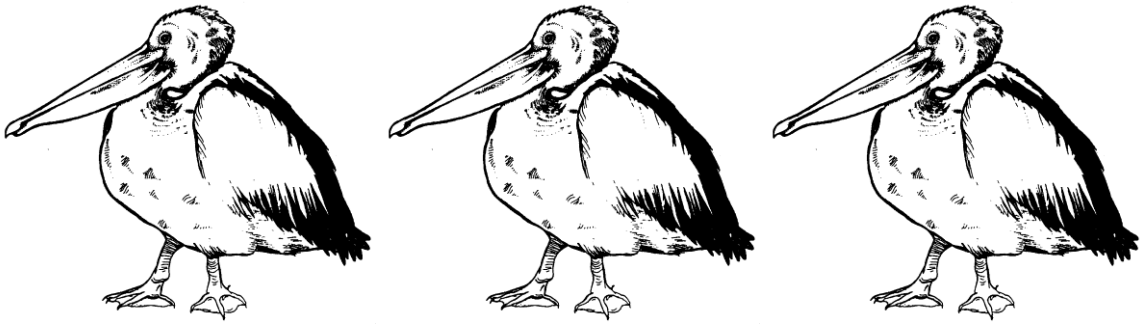
Pelican Place Pre-School and Development Center

City of Cape May
Department of Civic Affairs
643 Washington Street
Cape May, NJ 08204
Office: Convention Hall – 609-884-9565



Student's Name: _____ Sex: _____

Address: _____ Phone: _____

City, State, Zip:_____ Cell#: _____

Date of Birth: _____ Height: _____ Eyes: _____ Hair: _____

Parent's Names: _____

Occupations: _____

In Case of Emergency Child may be left with:

Name:_____ Phone:_____ Relationship:_____

Address:_____

Family Doctor/Pediatrician: _____Phone:_____

List any current medical problems under treatment. Include all present medicines of which your child now receives, the dosage and when administered. List any allergies. Does the child wear glasses, hearing aid, corrective shoes, etc. _____

Please list siblings and their ages: _____

Do other family members live with immediate family: _____

Please underline any/all symptoms that best describe your child/children:

Very Active	Moody	Awkward	Friendly
Withdrawn	Poorly Coordinated	Quiet	Aggressive
Sensitive	Quick Tempered	Easily Confused	Dependent
Nervous	Short Attention Span	Easily Frustrated	Shy
Happy	Good Natured		

Please underline how your child reacts when tired, exhausted, and fatigued:

Sleepy Lazy Quiet Excitable Irritable Stubborn

Are you aware of any tensional behavior such as nail biting, eye blinking, tantrums, tongue chewing or extensions, etc.? Yes_____ No_____

If yes, please describe when most noticeable: _____

What hand does your child use eating _____ writing _____

Does your child nap? _____

How does your child react to being corrected /disciplined?

Cooperative Rebellious Cries Tantrums Sulks

Childs previous socialization experiences: (list camp, Sunday school, etc.)

_____

Does your child know his/her age and sex? Yes_____ No_____

Does your child know his/her birthday? Yes_____ No_____

Does your child know his/her telephone number? Yes_____ No_____

Does your child know his/her home address? Yes_____ No_____

*Abilities and Interests: Does your child have difficulty in any of the following areas (underline)

Speech Removing clothing Hearing Dressing Self Co-ordination

Feeding Self Recognizing shapes/sizes Recognizing colors Zippering Buttoning

Lacing Distinguishing likenesses/differences Caring for toilet needs Following directions

Does your child have any special fears? _____

Please indicate degree of your child's interest in the following:

	Likes	Dislikes	Tolerates
Listening to stories	_____	_____	_____
Walking Trips	_____	_____	_____
Music	_____	_____	_____
Art	_____	_____	_____
Active Games	_____	_____	_____
Quiet Games	_____	_____	_____

Other Interests or Hobbies: _____

Does your child generally get along with other children? Yes_____ No _____

Which age group and sex does your child seem to play best?

Same age girls Older girls Younger girls

Same age boys Older boys Younger boys

This questionnaire, fully filled in, is essential in order for us to work an effective program for your child. A great deal of communication is also needed between the teacher and the parent(s). Parent /Teacher conferences may be necessary.

If you feel there is additional information that would benefit the teacher please note it here:

_____

_____

My child has permission to go on Walking Field Trips during the school year. Yes/No

My child has had a Physical recently and is in good health. Yes/No

My child may receive Emergency Medical Treatment if necessary. Yes/No

What Kindergarden will your child be attending when of age? _____

Parent(s) / Guardian(s) Signature & Date

_____

_____