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: _____

1st Parent's Occupation: _____
How many hours per day does 1st Parent work? _____
How often is 1st Parent out of town? _____
2nd Parent's Occupation: _____
How many hours per day does 2nd Parent work? _____
How often is 2nd Parent 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
Does your child still nap? Yes No For how long?_____

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? _____
_____