CIRCLE of FRIENDS PRESCHOOL
est'd 1967
at manchester umc

One and Two Year Old Program

GETTING TO KNOW YOU

Dear Parents,

In order to understand your child better, we are asking for the following information. The information will be used by the teachers to become acquainted quickly with your child. Please return this form by **August 1, 2018**.

First Name _____ Last Name _____

Name child goes by_____ Date of Birth _____

Home # (_____)_____ Parent #1 Cell (_____) _____

Parent #2 Cell (_____)_____

Parent #1's Name _____

Parent #1's Occupation _____

Parent #2's Name _____

Parent #2's Occupation _____

Names and ages of siblings _____

_____

If not the parent, please list name and relationship (i.e., nanny, grandparent, etc.) of anyone who is a regular care provider for your child.

_____

List names and type of pets _____

List child's favorite: activities _____

toys _____

story/book _____

song _____

Any fear of animals? Yes No Fear of noises? Yes No

Fear of something else? Yes No If yes, please describe _____

Please list any "comfort item(s)" (i.e., pacifier, blanket, stuffed animal, etc.) if your child uses them:

_____

What are your expectations for your child's Circle of Friends experience?

_____

_____

OVER ➡

Who referred you to COF? _____

In what school district do you reside? _____

Is your child seen by someone from Parents as Teachers? Yes No
If yes, the name of your Parents as Teacher Educator: _____

Has your child received any developmental screenings? No Yes, date:_____

Is your child currently receiving any special services (i.e., speech, physical therapy, etc.)? Yes No
If yes, please explain: _____

Is your child attending any other child care program? Yes No
If yes, please list the frequency your child attends: _____

What is the primary language spoken at home? _____

What languages are spoken at home? _____

Any special diapering or potty training concerns? _____

What words do you use for potty learning? _____

Does your child have any special medical issues (i.e., asthma, seizures, prematurity, etc.)? Yes No
If yes, please explain: _____

_____

Does your child have a food allergy, sensitivities, dietary restrictions, etc.? Yes No
If yes, please explain: _____

Please list any medications your child is currently or routinely taking: _____

_____

Is there anything your teachers should know that would help your child at school? _____

_____

_____

Parent's Signature _____ Date _____