

Student Questionnaire

Student Information

**Please note that all information given on this form will remain confidential*

Student Name _____ Date of Birth _____
(d/m/y)

What form of child care has your child had previously? Please explain. _____

Does your child nap during the day? If so, at what time and for how long? _____

What signs of fatigue does your child exhibit? _____

Does your child have any dietary restrictions? If so, explain. _____

What signs of hunger does your child exhibit? _____

Has your child had group play experiences? If so, where and how often? _____

What are your child's favourite indoor and outdoor activities? _____

Does your child experience any separation anxiety? _____

Does your child dress him or herself at home? _____

How do you discipline your child? _____

Is your child left or right handed? _____

Is your child toilet trained? _____

How would you describe your child's personality? _____

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What areas would you like to see your child's potential more fully developed?

What past illnesses has your child had? At what age?

Chicken Pox _____ age

Scarlet Fever _____ age

Mumps _____ age

Measles _____ age

Hepatitis _____ age

Any complications? _____

Has your child had any serious accidents? Explain. _____

Does your child have allergies? If so, to what and how do they normally manifest themselves? _____

Does your child have frequent: Tonsilitis Ear Aches Stomach Aches Nose Bleeds Colds

Explain _____

Does your child have any learning, behavioural or developmental needs? _____

Any other comments that you feel will assist us in the care of your child? _____

Please provide us the names and birthdays of parents, grandparents, siblings and other household members