

OAK GROVE MONTESSORI SCHOOL
STUDENT BACKGROUND HISTORY

Child's Name: _____ DOB : _____

Parent Completing this Form: _____

Please respond to the following questions as specifically as possible. This information will assist our staff in working with your child in the school environment.

Does your child nap? _____ Bed Time? _____

On play equipment will your child climb with ease?

What are your child's top three activities at home? 1. _____ 2. _____ 3. _____

Does your child have any fears? If yes, name them: _____

Will your child cuddle and enjoy having their back or hands rubbed at bedtime?

Did your child have any trouble with nursing or feeding from a bottle at birth?

At what age did your child crawl? _____, walk _____, run, _____, climb? _____

Does your child/family speak a second language?

Does your child have any food allergies? If yes, what are they? _____

How does your child most often respond to conflict with siblings. _____ crying _____ whining, _____ blaming, _____ yelling, _____ hitting, _____ pushing.

Was the delivery of your child considered typical? If not, please explain. _____

Does your child have any clothing preferences? (Example: short sleeves, no socks, only soft cotton.) _____

How does your child feel about food or dirt being on their hands and or face? _____

Does your child like to play with sand? _____, play-doh _____

Has your child had any repetitive illnesses?

Ear infections Yes No
Strep Throat Yes No
Sinus Infections Yes No

Was your child seen by an:

ENT (Ear, Nose & Throat)? Yes No
Allergist? Yes No
Ophthalmologist? Yes No

If yes, please explain:

Has your child ever been hospitalized? If yes, please explain: Yes No

Has your child ever taken any food supplements or vitamin supplements? Yes No
If yes, when and what type?

Does your child sleep alone? Yes No

Does your child snore during sleep? Yes No

Does your child sleep through the night uninterrupted? Yes No
If no, what happens?

Does your child like bath time? Yes No

What type of riding toys can your child use with ease?

Riding scooter toy-pushing with feet Yes No
Tricycle using pedals Yes No
Bicycle with training wheels Yes No
Bicycle without training wheels Yes No

Was your child full-term? Yes No
If no, how many weeks? _____

Will your child stay seated during a 30-minute television show? Yes No

Does your child require any special procedures while in our care? Yes No

What activities has your child participated in other than school?

What are your educational goals for your child?

What type of eater is your child?
Has this differed or been consistent from year to year?