OCEANSIDE UNION FREE SCHOOL DISTRICT

Oceanside, N.Y. 11572

PRE-K & KINDERGARTEN INTAKE FORM

Child's Name: _____ Date of Birth: _____

Address: _____ Male ____ Female ____

_____ Home Phone: _____

Parent(s)/Guardian(s)--Please list below:

Mother's Name: _____

Mother's Occupation _____ Business/Cell No: _____

Father's Name: _____

Father's Occupation _____ Business/Cell No: _____

Guardian(s) Name(s) (if applicable): _____

Guardian's Occupation _____ Business/Cell No: _____

Current Marital Status of Parent(s)/Guardian(s)--Please Circle <u>One</u>: Married Single Parent

Not Married Widowed Divorced Separated Other_____

Names and Ages of Siblings, if any, please list:

_____ _____

_____ _____

_____ _____

Did your child attend a **4-year-old** pre-school/nursery/daycare program (please circle)? Yes No

If yes, name of school/program: _____

Address: _____ Phone No: _____

Number of days per week: _____ Number of hours per day: _____

Did your child attend a **3-year-old** pre-school/nursery/daycare program (please circle)? Yes No

If yes, name of school/program: _____

Address: _____ Phone No: _____

Number of days per week: _____ Number of hours per day: _____

Has your child been hospitalized at all since birth, or had any serious illnesses/injuries? Yes No

If yes, please explain, noting reason and date: _____

_____

_____

Does your child have any significant allergies (e.g., food allergies, seasonal allergies) that could affect his/her in-school performance? Yes No

If yes, please explain and note how your child reacts to the allergies: _____

_____

_____

Is your child under any medical treatment now, and is he/she taking any medication? Yes No

If yes, please explain and list current medications: _____

_____

_____

Does your child suffer from frequent colds or ear infections? Yes No

If yes, please explain: _____

Do you have any concerns about your child's vision? Yes No

If yes, please explain: _____

Has your child ever been seen by an eye doctor (e.g., optometrist, ophthalmologist)? Yes No

If yes, please provide doctor's name, and the results of the examination: _____

_____

Do you have any concerns about your child's hearing? Yes No

If yes, please explain: _____

Has your child's hearing ever been tested? Yes No

If yes, when? _____Where? _____

What were the results/recommendations? _____

_____

Has your child ever seen a dentist? Yes No

If yes, please state reason, date and results: _____

_____

Do you have any other significant health concerns about your child? Yes No

If yes, please explain: _____

_____

Does your child receive, or have a history of receiving services through

Early Intervention (EI) or the Committee on Preschool Special Education (CPSE)? Yes No

If yes, please explain/list: _____

_____

_____

Does a parent, sibling, or close relative receive, or have a history of receiving special education services? Yes No

If yes, please explain: _____

_____

Are there any languages, **other than English**, spoken in the home (including caretakers, grandparents, etc.)? Yes No

If yes, please indicate what language is spoken, and by whom (e.g., Spanish, Grandparents)?

_____

If your child speaks a language **other than English**, do you have any concerns about his/her speech and language development in that language? Yes No

If yes, please explain: _____

_____

Do you have any significant concerns about your child's ability to learn (e.g., pre-academic skills, thinking, problem-solving skills, following directions)? Yes No

If yes, please explain: _____

_____

Do you have any significant concerns about your child's speech and language development (e.g., talking or understanding)? Yes No

If yes, please explain: _____

_____

Do you have any significant concerns about your child's motor skills (e.g., coloring, cutting, drawing, walking, running, balancing)? Yes No

If yes, please explain: _____

_____

Do you have any significant concerns about your child's self-care skills (e.g., toileting, feeding, dressing)? Yes No

If yes, please explain: _____

_____

Do you have any significant concerns about your child's social-emotional skills (e.g., separation anxiety, ability to play/interact with others)? Yes No

If yes, please explain: _____

_____

Do you have any significant concerns about your child's activity level and/or attention span (e.g., excitable, impulsive, difficulty sitting still, inattentive, easily distracted)? Yes No

If yes, please explain: _____

_____

Is there any information about your family that you feel would be important to share with the school team? Yes No

If yes, please explain: _____

_____

Please note any additional concerns you have regarding your child, or any information you think would be helpful to know about your child as he/she gets ready to come to kindergarten:

_____

_____

I understand that all information provided will be treated confidentially

Name of Person Completing Form: _____

Relationship to Child: _____

Signature: _____ Date: _____

Revised 10/12