Island Christian Academy
5373 Maxwelton Road
Langley, WA 98260
360-221-0919

Preschool/Pre-K Admissions Information

Child's
Last Name_____First_____Middle_____

Nickname_____ Age _____

ATTENDANCE

Days of the week (2 – 5 days):

Monday Tuesday Wednesday Thursday Friday

_____AM (8:45 - 12pm) _____PM (12 – 3:30pm) _____All Day (8:45 – 3:30pm)

PERSONAL HISTORY

Would you describe the child as active or quiet?_____What are the child's interests and activities?_____

_____

What are the child's favorite toys?_____

Does the child have any specific fears that you are aware of?_____

SOCIAL RELATIONSHIPS

Has the child had play experience with other children?_____Ages?_____

Has the child had previous experience in a preschool/daycare setting?_____

By nature, is the child: Friendly?_____Aggressive?_____Shy?_____Withdrawn?___

EATING

Does the child eat with a spoon?_____fork?_____hands?_____

General attitude toward eating:_____

Special likes:_____

Special dislikes:_____

Allergies:_____

Is the family vegetarian?_____Other dietary restrictions?_____

TOILETING

Does he/she have accidents?_____At nap?_____At night?_____

Is your child fully responsible for his/her own toileting?_____If not, what assistance does he/she need?_____

Can the child be relied on to indicate his/her bathroom wishes?_____

What expressions does the child use to make his/her wants known?_____

Word child uses for urination?_____Bowel movements?_____

Can the child dress him/herself?_____Does he/she need help putting on shoes? _____

SLEEPING

Night sleep from_____to_____Afternoon nap?_____How long?_____

What is his/her mood upon wakening?_____

What methods is useful in helping your child settle down for sleep?_____

_____

BEHAVIOR

Methods parents find most effective in dealing with good behavior:_____

_____

Methods parents find most effective in dealing with misbehavior:_____

_____

CHILD'S HEALTH INFORMATION

Date of child's last physical exam:_____

Child's health care provider_____Telephone number_____

Street Address_____City_____Zip Code_____

Hospital Choice:_____

Has the child had: Chicken Pox_____Measles_____Mumps_____Whooping Cough_____

Please indicate below if your child has had:

Asthma, convulsions, fainting spells, diabetes, frequent sprains or dislocations, operations, hospitalizations, heart disease, strep throat, serious injury or concussions, ear infections, urinary tract infections, anemia or any other condition that affects your child physically or emotionally:

Condition_____Description_____Date(s)_____

Condition_____Description_____Date(s)_____

Does the child have a handicap such as hearing or vision or problems that would be given special consideration?_____

Any allergies, including drug reactions? Yes____ No____ If yes, specify below:

Food_____Drugs_____

Comments:_____

Regular medications? Yes_____No_____If yes, specify_____

_____

Other important information? Yes_____No_____If yes, specify_____

_____

Child's dentists name_____Telephone number_____

Street Address_____City_____Zip Code_____