Student Information Form

Student Name: _____

Name of person completing form:_____

Relationship to Student:_____Contact No:_____

Please complete the following form as it provides the school and teachers with important background information on your child. This form will be kept confidential and will assist us to develop your child's early learning program.

Who are the members of your child's household/family?

Who are the main people with whom the child interacts?

Do they have any siblings at this school? Yes / No If so, who?

_____

Has/does your child attend day care? Yes / No

Were there complications during pregnancy/birth? Yes / No

Does your child have a diagnosed medical condition? (If so, what?) Yes / No

_____

Has your child ever seen any of the following specialists?

- **Paediatrician Yes / No**
- **Occupational Therapist Yes / No**
- **Ear/Nose and Throat Specialist Yes / No**
- **Speech Therapist Yes / No**

Has your child ever had ear infections/grommets? Yes / No

At what age did your child first start saying 2 and 3 word sentences? _____

Do people outside the family have difficulty understanding your child's speech? Yes / No

_____

Is your child able to understand and follow simple instructions? Yes / No

Does your child have any issues with the following? (if so, please comment)

Toileting Yes / No _____

Sleeping Yes / No_____

Movement Yes / No_____

Socialising with friends Yes / No_____

Interacting with adults Yes / No_____

Do you have any concerns with your child's behaviour? 9if so, please comment) Yes / No

_____

_____

Have any family members had any learning difficulties? (if so, please comment) Yes / No

_____

_____

Thank you for completing this form.

Bridgetown