

# CHARLIE BROWN PRESCHOOL & CHILDCARE

## Intake Sheet

### **I. Child's Identification Information**

Name:	Nickname:
Address:	Phone:
Sex:	Date of Birth:

### **II. Family Information: Parents or Guardians**

Name	Address	Place of Employment	Work Phone
_____	_____	_____	_____
_____	_____	_____	_____

\_\_\_Single    \_\_\_Married    \_\_\_Divorced    \_\_\_Separated    \_\_\_Foster Parent    \_\_\_Deceased

Names and Birthdates of other children in the home:

_____	_____
_____	_____
_____	_____

### **III. Child's Medical History**

\* Allergies (goods, medications, bees, etc.) \_\_\_\_\_

\* Chronic or recurrent illnesses or diseases (asthma, seizures, diabetes, etc.) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

(Please write "NONE" if your child has no medical problems)

Does your child take medication for this condition? \_\_\_Yes \_\_\_No

If yes, please state the name and dosage \_\_\_\_\_

Will the medication need to be given during program hours? \_\_\_Yes \_\_\_No

If yes, when and how is it to be given? \_\_\_\_\_

What should we do if your child has a problem related to her/his medical conditions during program hours?

\_\_\_\_\_

\_\_\_\_\_

**IV. Play and Sociability**

\* How does your child get along with other children? \_\_\_\_\_  
\_\_\_\_\_

His/Her usual playmates are \_\_\_girls \_\_\_boys \_\_\_older \_\_\_younger \_\_\_none

\* What is the usual size of your child's neighborhood playgroup? \_\_\_\_\_

\* Previous group experiences other than school: \_\_\_ Preschool \_\_\_Playgroup \_\_\_ Other(specify)  
\_\_\_\_\_

**V. Personality and Emotional Development**

\* Does she/he accept new people easily? \_\_\_Yes \_\_\_No

\* What are your child's fears? \_\_\_\_\_

\* Is your child usually happy? \_\_\_Yes \_\_\_No

\* What nervous habits does you child have? \_\_\_\_\_

**VI. Other Information**

\* Does your child have any unusual eating problems or food dislikes? (Explain)  
\_\_\_\_\_  
\_\_\_\_\_

\* What is your child's usual bedtime? \_\_\_\_\_ usual waking time? \_\_\_\_\_

\* What is your child's attitude toward taking a nap? \_\_\_\_\_  
\_\_\_\_\_

Urination

Bowel Movement

\*How does he/she state need? \_\_\_\_\_

\*How dependable is he/she? \_\_\_\_\_

\*Do you consider your child to be:

Right-handed \_\_\_\_\_ Left-handed \_\_\_\_\_ Not sure \_\_\_\_\_

\*Give any further information that would be helpful in understanding your child or would enhance your child's experience in our program. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_