CABOT montessori school

4100 South 1st Street
Cabot, AR 72023
(501) 605-7401
www.cabotmontessori.net

Personal History

Child's Name: _____ Date of Birth: _____
Last *First* *M.I.*

Preferred Name: _____

Current Age: _____ Gender: MALE ☐ FEMALE ☐

Household Members

Name: _____ Relationship: _____ Age: _____

Name: _____ Relationship: _____ Age: _____

Name: _____ Relationship: _____ Age: _____

Name: _____ Relationship: _____ Age: _____

Name: _____ Relationship: _____ Age: _____

Are both parents living in the household? YES ☐ NO ☐

Is either parent deceased? YES ☐ NO ☐

Is either parent away from home for long periods of time? YES ☐ NO ☐

Does your child relate well to other family members? YES ☐ NO ☐

Describe any tensions in the family we should be aware of: _____

Experience with Non-Family Members

Has your child attended another school or daycare? YES ☐ NO ☐

Name: _____ Begin Date: _____ End Date: _____

Name: _____ Begin Date: _____ End Date: _____

Name: _____ Begin Date: _____ End Date: _____

Describe your child's adjustment to activities outside of family events (e.g., school, Sunday School, camp) including their reaction to other caregivers (e.g., teachers, counselors):

Daily Routine

	YES	NO
Does your child sleep well at night?	☐	☐
Does your child take a nap during the day?	☐	☐

What time does your child wake up? Go to bed? _____ AM _____ PM

Describe any concerns about your child's sleeping habits or known disruptions to your child's daily routine:

Health

	YES	NO
Does your child have any allergies?	☐	☐
Does your child wear glasses, hearing aid, orthopedic shoes/braces, or another medical device?	☐	☐
Does your child require medication?	☐	☐
Does your child experience seizures?	☐	☐
Does your child have motor difficulties?	☐	☐
Does your child have language difficulties?	☐	☐
Does your child have a learning disability?	☐	☐

If the answer is yes to any of the above questions, describe, in detail, the issue and the required special care:

Describe any additional special needs, limitations, and/or concerns (e.g., potty training issues, language delays, food dislikes):

Describe any fears or anxieties your child may have or has had in the past. If possible, relate to significant events in their life (e.g., new baby, moving house, divorce, deaths, accidents, hospitalizations) :

Signature: _____ Date: _____