



All Saints Preschool  
3 Chevy Chase Circle  
Chew Chase, MD 20815  
(301) 654-2488, x233

### STUDENT INFORMATION RECORD

Legal Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_ Male Female  
Starting Date: \_\_\_\_\_ Class: \_\_\_\_\_ Withdraw Date: \_\_\_\_\_  
Address: \_\_\_\_\_ Home Phone #: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Email: \_\_\_\_\_  
Mother/Guardian: \_\_\_\_\_ Cell # \_\_\_\_\_  
Employer: \_\_\_\_\_ Work #: \_\_\_\_\_  
Father/Guardian: \_\_\_\_\_ Cell #: \_\_\_\_\_  
Employer: \_\_\_\_\_ Work #: \_\_\_\_\_  
Student Resides With: \_\_\_\_\_

### MEDICAL HISTORY (pertinent information)

Were there any special circumstances surrounding the child's birth? Yes No Describe: \_\_\_\_\_  
\_\_\_\_\_

Any problems with speech, hearing, or general health? Yes No Describe: \_\_\_\_\_  
\_\_\_\_\_

Allergies Documented? \_\_\_\_\_ Life-threatening? Yes No

*\*\* If yes, complete back of MSDE/OCC Emergency Form*

Has your child ever been hospitalized? Yes No Describe: \_\_\_\_\_

### FAMILY HISTORY

Family Nationality? \_\_\_\_\_

Does your child speak/understand English? Yes No

Language spoken at home: \_\_\_\_\_

Does your child take a nap? Yes No

Does your child sleep well at night? Yes No

Bed time: \_\_\_\_\_ Awakening time? \_\_\_\_\_

Does your child have any particular fears? Yes No Describe: \_\_\_\_\_  
\_\_\_\_\_

If the parents are divorced, does the child see the noncustodial parent regularly? Yes No

Describe: \_\_\_\_\_

Name all of the people living in the home. Include the relationship and ages of the siblings: \_\_\_\_\_

\_\_\_\_\_

How long has the child lived in this area? \_\_\_\_\_

Pets? Yes No Describe: \_\_\_\_\_

Does your child have any particular friends? Yes No Names: \_\_\_\_\_

\_\_\_\_\_

Does your child watch television? Yes No What type(s) of programs? \_\_\_\_\_

\_\_\_\_\_

How many hours/day of TV, movies, computer & video games? \_\_\_\_\_

\_\_\_\_\_

Outside of school, does your child play actively with peers? Yes No

Approximately how many hours per week? \_\_\_\_\_

### EDUCATIONAL HISTORY

Is this your child's first school experience? Yes No

List other programs and attendance dates: \_\_\_\_\_

Name the personality traits you feel best describe your child: \_\_\_\_\_

\_\_\_\_\_

What techniques best motivate your child? \_\_\_\_\_

What is the most effective discipline procedure used at home? \_\_\_\_\_

Are there any reasonable and appropriate accommodations in a group setting requested for your child?

Yes No If yes, indicate adaptations on MSDE/OCC "All About My Child" form.

Do you have any specific concerns regarding your child? Yes No Describe: \_\_\_\_\_

\_\_\_\_\_

Additional Comments: \_\_\_\_\_

Parent/ Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_