Student Information Form

Student Name: ____

Name of person completing form: ____

Relationship to Student: ________________________ **Contact Number:** ________________________

Please complete the following form as it provides the school/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 the 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 any complications during pregnancy/birth? Yes / No

Does your child have any diagnosed medical conditions? (if so, what?) Yes / No

____

Has your child ever seen and 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? (if so, please comment) Yes / No

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

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Thank you for completing this form.

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