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Executive Director

**WHISPERING PINES PRESCHOOL
EARLY LEARNING PROGRAM**

BRIEF HEALTH AND SOCIAL SUMMARY

CHILD'S NAME: _____ D.O.B.: _____

SCHOOL DISTRICT: _____ COUNTY: _____

GENERAL HEALTH:

Does your child have any health problems or unusual health patterns? _____

Is your child prone to ear infections: ___ Yes ___ No

Does your child have ear tubes? ___ Yes ___ No

Is your child prone to high fever: ___ Yes ___ No

o How high is usual: _____

Is your child prone to Croup: ___ Yes ___ No

Does your child have any allergies? ___ Yes ___ No

List allergies: _____

What communicable diseases has your child had? _____

Has child ever been hospitalized? _____ When: _____

Why? _____ Family Physician: _____

Is your child diagnosed with Asthma? ___ Yes ___ No

Does your child use a nebulizer? ___ Yes ___ No

Does your child use an inhaler? ___ Yes ___ No

1. Is there anything regarding the eyes, ears, speech, recent injuries to general health that the center should know about in order to provide the best understanding of your child?

MEALTIME

1. What food allergies does your child have? _____
2. Any foods your child dislikes? _____
3. Any special dietary needs? _____

PERSONAL HYGIENE

1. Does your child:
 - dress self _____
 - need assistance with what clothes? _____
2. Child usually naps from: _____ to _____
3. Does your child have trouble falling asleep? _____
4. Any special bedtime habits or possessions? _____
5. Does your child have any bedtime fears? _____

GENERAL

1. Tell us about your child's social emotional development/behavior.

2. What are your child's favorite play activities?

3. What forms of discipline do you use at home?

4. Please explain if your family is in the process of any kind of change at home.

5. Are there any significant others in your child's life other than the immediate family?

FAMILY

Please list the names, ages and relationships of all persons living with your child.

Name	Date of Birth	Relationship (Brother, Sister, Parent, Etc.)