



Our Lady of the Lake School  
 175 East 200<sup>th</sup> Street  
 Euclid, Ohio 44119  
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**Our Lady of the Lake Preschool**

Child's name \_\_\_\_\_ Birthdate \_\_\_\_\_ Age \_\_\_\_\_  
                     First                    Middle                    Last

Address \_\_\_\_\_  
 Phone Numbers \_\_\_\_\_ School Zone \_\_\_\_\_  
 Child's Social Security Number \_\_\_\_\_  
 SSI \_\_\_\_\_ Yes \_\_\_\_\_ No

**I. DEMOGRAPHIC INFORMATION**

Mother's Name (or female guardian if different) \_\_\_\_\_ Father's Name (or male guardian if different) \_\_\_\_\_  
 \_\_\_\_\_  
 Age \_\_\_\_\_ Age \_\_\_\_\_  
 Occupation \_\_\_\_\_ Occupation \_\_\_\_\_  
 Employer \_\_\_\_\_ Employer \_\_\_\_\_  
 Marital Status \_\_\_\_\_ Marital Status \_\_\_\_\_

**LIST BROTHERS AND SISTERS: (Use additional sheet if necessary)**

<u>Name</u>	<u>Age</u>	<u>Sex</u>	<u>Living at Home</u>
_____	_____	_____	Yes _____ No _____
_____	_____	_____	Yes _____ No _____
_____	_____	_____	Yes _____ No _____
_____	_____	_____	Yes _____ No _____

**LIST OTHER PERSONS WHO ARE CURRENTLY LIVING IN THIS HOME:**

<u>Name</u>	<u>Age</u>	<u>Sex</u>	<u>Relationship</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

With whom does the child reside? \_\_\_\_\_  
 What is the child's home language? \_\_\_\_\_

**II. AREAS OF CONCERN (Check all that apply)**

\_\_\_ Behavioral/emotional    \_\_\_ Slow development    \_\_\_ Speech difficult to understand  
 \_\_\_ Immature language usage    \_\_\_ Vision problems    \_\_\_ Slow motor development  
 \_\_\_ Listening    \_\_\_ Uneven development    \_\_\_ Health/medical  
 \_\_\_ Other \_\_\_\_\_

### III. MEDICAL INFORMATION

Does the student have frequent illnesses (e.g., allergies, ear infections, PE tubes, seizures)?

Yes  No If yes, please explain: \_\_\_\_\_

Does the child have any other medical problems?  Yes  No If yes, please explain: \_\_\_\_\_

Does the child regularly take medication?  Yes  No If yes what medication(s), dosage and frequency? \_\_\_\_\_

Why? \_\_\_\_\_

Does the child wear glasses or have vision problems?  Yes  No

If yes, please explain: \_\_\_\_\_

Does the child appear to hear well?  Yes  No

Does the child have hearing aids?  Yes  No

### IV. DEVELOPMENTAL HISTORY

Motor Development (List appropriate age)

Crawled \_\_\_\_\_ Walked alone \_\_\_\_\_ Toilet trained \_\_\_\_\_ Fed self with a spoon \_\_\_\_\_

Speech and Language (List appropriate age)

Spoke first words \_\_\_\_\_ Used two word sentences \_\_\_\_\_ Spoke in complete sentences \_\_\_\_\_

Yes  No Does your child communicate primarily using gestures?

Yes  No Does your child communicate primarily using speech?

Yes  No Is your child's speech difficult for others to understand?

Yes  No Does your child have difficulty following directions?

Yes  No Does your child answer questions appropriately?

Social Development

What opportunities does your child have to play with other children of his/her age? \_\_\_\_\_

What play activities does your child enjoy? \_\_\_\_\_

Does s/he play primarily alone?  With other children?  Does s/he enjoy pretend play?

Do you have concerns about your child's behavior?  If yes, please explain: \_\_\_\_\_

### V. PRESCHOOL HISTORY

Preschool or daycare programs attended

Name \_\_\_\_\_ Address \_\_\_\_\_ Dates \_\_\_\_\_

Name \_\_\_\_\_ Address \_\_\_\_\_ Dates \_\_\_\_\_

List any special services from a school or other agency that the child has received in the past (i.e, speech therapy, physical therapy, Children's Special Services at Health Department, counseling, etc.)

Type of Service \_\_\_\_\_ Dates \_\_\_\_\_ School/Agency \_\_\_\_\_

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Completed by: \_\_\_\_\_ Date completed: \_\_\_\_\_

Signature(s): \_\_\_\_\_