Pembroke Public Schools

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North Pembroke Elementary School
72 Pilgrim Road, Pembroke, MA 02359

INTEGRATED PRESCHOOL PEER APPLICATION
2022-2023 School Year

Date____________________

Child's Last Name: ________________________First:____________________Middle:________________

Home Address____

____
Town State ZIP

Age on September 1, 2022_______ Date of Birth__________________________ Sex M F
(child must be 3 by September 1, 2022)

(Please choose one, checking more than one option will void your application)

_______I am interested in the four-day (half-day) program M-Th 8:15-11:00 AM/ 12:00-2:45PM

_______I am interested in the five day (full-day) program M-F 8:15 AM-2:45 PM

Parent/Caregiver #1	**Parent/Caregiver #2**
Name: ____________________________	Name: _______________________________
Address: __________________________	Address: _____________________________
Phone: ______________________	Phone: _________________________
Email:______________________________	Email: _______________________________

Has your child been identified as having special needs? __________yes __________no

All children must participate in a child find screening for this program. You will be contacted to schedule an appointment for your child after returning this application.

OUR MISSION: To ensure student achievement through excellence in teaching and learning.

Parent Questionnaire Form

Dear Parent:

Please answer the questions on this form in the best way that you can. You will be able to answer some quite easily and you will have difficulty in making a decision on others.

Your answers on this form will help the preschool staff decide what kind of educational program is best suited for your child.

This questionnaire is confidential and your responses are shared only with professional personnel.

Child's Name_____________________________________ Today's Date__________________

Street Address____

Sex M F Date of Birth_____________________ Birthplace_____________________

Telephone Number: Home_________________________ Cell__________________________

Name of Person (s) Filling Out Form_________________________________ Relationship to Child________________________

Parent email address:_____________________________

1. Child's School History

Has your child attended school before? __________yes __________no

If yes, name of school____

Dates of attendance (month/year)___________________ to ____________________

Number of days per week: _____2 _____3 _____4 _____5 ___FT ___PT

Any other school experience? ____

2. Child's Status in Family

________oldest ________middle ________youngest ________only

Other children in family:

_______________________________ age_________ school ____________________
_______________________________ age_________ school ____________________
_______________________________ age_________ school ____________________

Do any of your children experience difficulty in school?

Name	School	Area of Difficulty
______________________	_______________________	_________________________
______________________	_______________________	_________________________

Has any family member or close relative had a significant difficulty in school?

If yes, Relationship_______________ Nature of Difficulty_______________________

3. <u>Parents</u>

Parent's/Guardian's Name____________________________ Occupation__________________

Place of Work______________________________________ Phone______________________

Parent email_______________________________________

Parent's/Guardian's Name____________________________ Occupation__________________

Place of Work______________________________________ Phone______________________

Parent email_______________________________________

Other persons residing in the household:

Names____

Relationship(s) ____

Have there been any extraordinary events in this household? (E.g. illness, moves, death, disaster, change in make-up of family)

____

____

Any serious parental or family health problems? ____

4. Basic Medical Data

Name of Child's Doctor___________________________ Telephone____________________

Address____

Has your child ever had any ear/hearing examination or treatment?

_____yes _____no If so, when? _______________________________________

Doctor___________________________ Results____________________________________

Ear infections? _____yes _____no If yes, _____Infrequent (2-3 times per year)
_____Frequent (4 or more per year)
_____Prolonged (10 days - 2 weeks)

Dates of ear infections____

Do you suspect any hearing problems? ________yes ________no

Does your child:

Seem to have difficulty hearing?	Yes	No
Turn up the TV louder than other members of the family?	Yes	No
Seem to favor one ear over the other?	Yes	No
Jump or appear to be more startled than others if there is a sudden noise?	Yes	No
Seem to hear you if you talk in a whisper?	Yes	No
Make you talk loudly or repeat frequently?	Yes	No

Has your child ever had a vision examination or treatment? ________yes ________no

If so, when? _________________________________ Doctor ____________________

Results____

Do you suspect any vision problems? ________yes ________no

Does your child:

Seem to have difficulty seeing small lines or pictures?	Yes	No
Seem to have a problem seeing things far away?	Yes	No
Squint?	Yes	No
Wear glasses?	Yes	No
Have eyes that turn in?	Yes	No
Have eyes that turn out?	Yes	No
Sit very close to the television?	Yes	No
Rub eyes frequently?	Yes	No

Give approximate age that your child spoke: _____________

First Words __________ 2 or 3 words together_________ Sentences_________

At what age did your child first begin to walk?
Give approximate age if you do not remember exact age: _____________

Do you feel your child has adequate large muscle coordination? _____yes _____no

Do you notice, or has your doctor reported, any of the following in your child?

	Asthma		Nose Bleeds		Frequent Fevers
	Constipation		Bed Wetting		Epilepsy (seizures)
	Diarrhea		Bed Soiling		Overtired/Lacking Pep
	Vomiting		Diabetes		Serious Blows to Head
	Headaches		Thumb Sucking		Lack of Consciousness
	Sinus Trouble		Heart Trouble		Hyperactivity
	Nail Biting		Allergies (type)		Food Allergies (specify)
	Chronic Ear Infections		Chronic Stomach Problems		Medical Problems Immediately after Birth

Comments: ____

____

Please check *Yes*, *Sometimes*, *No*, or *Not Sure* for each of the following statements:

It is my (our) opinion that our child:

	Yes	Sometimes	No	Not Sure
Has regular playmates the same age				
Has difficulty getting along with other children				
Has difficulty expressing self				
Prefers to play with other children instead of alone				
Is difficult to understand when talking				
Seems generally happy				
Is frequently irritable or moody				
Is upset by changes in routine				
Demands much individual adult attention				
Accepts discipline and limits				
Becomes confused in following more than two verbal directions at a time				
Has difficulty remembering things for a short time				
Has difficulty remembering things for a long time				
Is easily frustrated				
Cries easily				
Cooperates willingly				
Has a bad temper				
Can use a fork and spoon without help				

Can catch a ball thrown to him				
Enjoys physical activities				
Loses balance, trips, and falls				
Has difficulty running				
Is dealing with a family stress such as illness, death, or separation				

How old are your child's favorite playmates? ___________________________________

About how many hours a day does your child watch TV? _______________ Screen time: __________

What kinds of things do you like to do with your child? ____

____

Do you have any special concerns about your child? ____

____

Is your child toilet trained? ____

Is there any other information that will help us better understand your child?

____

Other physical problems or serious illnesses (explain) ____

____

Child's Birth Weight ________lbs. ________oz.

Special Considerations

_____Caesarean _____Child Rotated _____Premature

_____Cord around neck _____Breech _____Twin~1st born, 2nd born

_____Baby blue _____Baby yellow _____Baby bruised

_____Rh negative _____Transfused

Special Care

_____Oxygen (how long) ____

_____Incubator (how long) ____

_____Hospital stay (how long) ____

_____Seizures or loss of consciousness? ___________________________________

Is your child presently on medication? __________ What? ______________________

Has your child had any significant injuries or hospitalization? _________________________________

____

Is your child prone to certain ailments? (e. g. ear infections, stomach aches, etc.)

____

Has your child had Special Education needs in the past or currently?

____

Do you participate in any of the following programs? (*Please check*)

________Social Security ________Medicaid ________Welfare

________Food Stamps ________Aid for Dependent Children (AFDC)

Thank you for your cooperation in filling out this questionnaire.

I also give permission to preschool staff to take a photograph of my child, to remain in their file throughout the preschool admission process.

Name _____________________________________

Date______________________________________

Please return this completed application to the main office at North Pembroke Elementary School by 2:00PM on Monday, February 28, 2022.