

Park Tudor School
7200 N. College Avenue
Indianapolis, IN 46240
(317) 415-2777

Children's Resource Group
9106 N. Meridian Street, Suite 100
Indianapolis, IN 46260
(317) 575-9111

Dear Parents:

Please complete this form so that we may have a better understanding of your child prior to starting the admissions process. We appreciate your thoroughness and candor in responding to these questions. The original form should be returned to Children's Resource Group at the time of your child's developmental screening. A copy will then be forwarded to Park Tudor School with the report of the developmental screening.

Child's Name: _____ Nickname: _____

Date of Birth: _____ Date Completed: _____

Your name: _____ Relationship to Child: _____

FAMILY HISTORY

1. Please list all persons presently living in your home:

Name	Sex	Age	Relation to Child	Present or Highest Grade Completed

2. During the past 12 months, has your family experienced any of the following difficulties?

(If yes, please explain):

	Yes	No	Comments
Death of a family member			
Serious illness			
Marital problems			
Unemployment			
Other (please describe)			

3. Have any family members had tics, learning, developmental, attentional, or other medical/psychological problems? Yes No

If yes, please describe: _____

GENERAL INFORMATION

1. What is your child's favorite toy? _____

2. What is your child's favorite activity? (indoors and outdoors)? _____

3. How long does your child stay with an activity? _____

4. Does your child prefer to play alone? Yes No

With children his/her age? Yes No

With younger children? Yes No

With older children? Yes No

5. Does your child have any unusual skills or abilities for his/her age? Describe: _____

6. Does your child accept new situations readily? Yes No

Explain: _____

7. Does your child want to know "how objects or things work?" Yes No

Explain: _____

8. Does your child like being read to? Yes No

9. How long does your child attend to a story you are reading? _____

10. Can he/she repeat a simple story? Yes No

11. Can he/she count objects? Yes No How many? _____

COMMUNICATION

1. Language(s) other than English spoken regularly at home: _____

2. When did your child start to say single words? _____

3. When did your child put two or more words together? _____

4. Does your child use pronouns correctly? Yes No

5. Has your child had speech therapy Yes No

If yes, please explain: _____

6. Does your child confuse letters or syllables in words, such as *flutterby* for *butterfly*, etc?
 Yes No If yes, please explain or give examples: _____

7. Does he or she typically leave words out of sentences (i.e. *I going to school*)?
 Yes No If yes, please give examples: _____

MOTOR DEVELOPMENT

1. When did your child begin to crawl? _____

2. When did your child walk alone? _____

3. Does your child dress him/herself? Yes No

4. Does your child ride a tricycle? Yes No

A bicycle with training wheels? Yes No

A two-wheeled bicycle? Yes No

5. Does your child like to draw? Yes No

6. What is your child's preferred hand? _____

7. Family handedness: Mother _____ Father _____ Sibling _____

MEDICAL HISTORY

1. Were pregnancy and birth typical? Yes No If no, please explain: _____

2. How much did your child weigh at birth? _____

3. Was he/she breast fed? Yes No Formula? Yes No

4. Did he/she have ear infections before the age of two? Yes No Number: _____

5. Does your child have allergies? Yes No If yes, please explain: _____

6. Has your child had any health problems? Yes No If yes, please explain: _____

7. Is your child on any kind of medication? Yes No If yes, what? _____

8. Does your child have a severe reaction to insect bites? Yes No

If yes, please explain: _____

9. Has your child ever had trouble seeing? Yes No

10. Have your child's eyes ever looked crossed? Yes No

Child's Name _____

11. Does your child sleep all night? Yes No

Explain: _____

DAILY ROUTINE

1. Please give a brief description of a typical day for your child (i.e., 7am-wakes up, dresses self, breakfast; 8am-goes to day care with dad; etc.)

2. Does your child have a regular bedtime? Yes No

3. Is your child afraid of the dark? Yes No

4. Does your child have nightmares? Yes No If yes, how often? _____

Please use the space below to let us know of any additional information which would be helpful in knowing your child:

