Date_______________ **Date Application Received____________________**

Start Date___________________________________

KINDERFROGS SCHOOL APPLICATION ADMISSION AND SOCIAL HISTORY FORM

Please Print

Child's
Name____
(First) (Middle) (Last)

Date of Birth_________________________ _____ Age______________________Sex______________________

Child's Social Security Number______________________________ Place of Birth________________________

School District ______________________ Elementary School ___________________________________

FAMILY INFORMATION

MOTHER

Name____Home Phone___________________________

Address____

City____ State_____________ Zip Code________________

Highest Grade Completed in School____

Occupation____

Business/Email
Address____

Business
Phone____

Marital Status (Circle One) Single Married Separated Divorced

FATHER

Name____
Home Phone___________________________

Address____

City_________________________ State________ Zip Code ____________________________

Highest Grade Completed in
School____

Occupation____

Business/Email
Address____

Business Phone____

Marital Status (Circle One) Single Married Separated Divorced

PRIMARY CAREGIVER (If other than parent)

Name____HomePhone______________

Address____

City____________________ State_____ Zip Code___________

EMERGENCY TELEPHONE NUMBERS

Name____Relationship___________________

Home Phone__________________ Work Phone__________________
Cell Phone ___________________

Name____Relationship__________________

Home Phone__________________ Work Phone__________________
Cell Phone___________________

Name____Relationship___________________

Home Phone__________________ Work Phone__________________
Cell Phone_________________

LIST THE NAMES AND AGES OF YOUR OTHER CHILDREN

____

____

MEDICAL INFORMATION

During this pregnancy, did mother experience any unusual illnesses, conditions, or accidents? _____
(If yes, please describe)

____
____
____
____

Length of Pregnancy_____________________________________

Complications during delivery? _____ (If yes, please describe)

____
____
____

Birth Weight_______________ Did the baby have trouble breathing? _____ Yes _____ No (If yes, please describe)

____

____

Did the baby have feeding problems?____

Was the baby on a respirator?____ If so, how long?____

Did the baby have seizures?____

Other problems?____

Check the illnesses the child has had. Please indicate the child's age at the last occurrence and whether or not the child was hospitalized:

Illness	Yes	No	Age	Hospitalization
Measles	____	____	____	____
Chicken Pox	____	____	____	____
Mumps	____	____	____	____
Strep Throat	____	____	____	____
Scarlet Fever	____	____	____	____
Tonsillitis	____	____	____	____
Ear Infections	____	____	____	____
Seizures	____	____	____	____
Meningitis	____	____	____	____

Were any of these illnesses followed by noticeable changes in the child's general behavior?_____ Yes _____No (If yes, please describe)

____

____

Describe any surgeries the child has had

Surgery Date

-

____

____

____

Does your child have allergies? _____ (If yes, please list)____

____

List medication that your child may take on a regular basis:

Medication Why?

____

____

____

Please list the name(s) of your child's doctors:

____
Phone_________________________________

____Phone_____________________________

____Phone_____________________________

What is your child's current weight?________________________ Height?________________________

VISION

Does your child have vision problems? _____ Yes _____ No (If yes, please describe)

____

Date of the most recent vision test __________________________

Where tested?____

HEARING

Does your child have hearing problems? _____ Yes _____ No (If yes, please describe)

____

Date of the most recent hearing test ___________________ Test results ______________________________

Where tested ____

DEVELOPMENTAL EVALUATION
Does your child have any diagnosed developmental problems? _____ Yes _____ No (If yes, please describe)
____
____
____

Date of the most recent developmental evaluation:____________________________________

Test
results:____

Where
tested____

Has your child ever had Oral Therapy, Physical Therapy or Speech Therapy _______
Where ____

ADAPTIVE EQUIPMENT

Please indicate all adaptive equipment currently used by your child:

_____ Hearing Aid

_____ Glasses

_____ Splints

_____ Wheelchair

_____ Other
(describe)____

SOCIAL INFORMATION

Does your child currently attend a child care center/program? _____ Yes _____ No

If yes, where?
____

What are your child's most enjoyable
activities?____

____
____

What frightens your
child?____

____
____

What do you do to comfort your
child?____

What is your child's schedule for snack and lunch?____

____
____

What is your child's sleeping napping schedule?____

____
____

What are your child's favorite play things?____

____
____

List the places your child frequently visits:____

____
____

List the significant people in your child's life:____

____

EDUCATION/THERAPY SERVICES

List the therapy services your child has received:

Type of therapy__________________________
Therapist____

Address____
Phone______________________________

Type of therapy__________________________
Therapist____

Address____
Phone______________________________

Type of therapy__________________________
Therapist____

Address____ Phone ____________________________________

Person completing this form________________________ Relationship to child______________________