Wainscott Common School
47 Main Street – P.O. Box 79
Wainscott, NY 1197
(631) 537-1080

Name____
Last First Middle

Social Security #________________ Birthplace________________

Preferred name of child________________ Birth Date____________

Address____
Street Town Zip

Mailing Address____
if different

Father's Name____

Address____

Last grade attended in school ________________________________

Employer___________________________ Business Phone________

Mother's Maiden Name____________________________________

Address____

Last grade attended in school ________________________________

Employer___________________________ Business Phone________

Has there been a divorce or separation? ___Yes ____No ____Never married

Who has legal custody? ____________________________________

Other Children

Name	Birth Date	School/Grade

Have any of them had reading problems? _____ Yes _____ No
If so, who ___________________________

Languages spoken at home __________________________________

At what age was child able to make three word sentences such as "I want milk" or "Me want milk."? ___________________________

Does child speak clearly now? ___Yes ___No Fluently? ___Yes ___No

Do you think your child is average in height and weight? ___ Yes ___ No

Is your child right or left handed? ___________________

With which hand does child feed self? ____________________

Does child fall frequently? ___Yes ___No

Does child frequently bump into objects around him/her? ___Yes ___No

Has child ever indicated having trouble seeing things? ___Yes ___No

Can child button and unbutton easily? ___Yes ___No

Does child do simple household tasks? ___Yes ___No

Does child prefer to play with other children or alone?

____

Emotional

Is he/she doing well in school? ___Yes ___No

Does he/she get along with other children well? ___Yes ___No

Circle any of the following that apply to your child:

nail biting	irritable	bad temper
breath holding	doesn't mind	nightmares
jealousy	speech problems	can't toilet train
bed wetting	thumb sucking	other ______________

Last school attended ____________________________________

Last grade attended ______________ To enter grade ____________

Does child cry easily or frequently? ___Yes ___No

Do you consider the child overly shy? ___Yes ___No

Do you consider the child over-active? ___Yes ___No

Has child ever had a sleeping problem? ___Yes ___No

Is child toilet trained? ___Yes ___No

Other information you feel we should know about your child:

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