



STUDENT HISTORY FORM

Date: \_\_\_\_\_

This questionnaire is intended to help your child's teacher better understand your child. Answering these questions is to be done voluntarily and all information will be kept confidential. Please complete this form and submit it with your enrollment forms. Thank you!

Child's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Are both parents living at home with your child? Yes \_\_\_\_ No \_\_\_\_

If not, please describe custody/guardianship arrangements: \_\_\_\_\_  
\_\_\_\_\_

Siblings:	Name	Age
	_____	_____
	_____	_____
	_____	_____

Are there any other family members/people living with the child? Yes \_\_\_\_ No \_\_\_\_

If so, who? And relationship to the child \_\_\_\_\_

Are there other languages spoken in the home and if, which ones? \_\_\_\_\_

Have there been any unusual occurrences in the life of your child which have been traumatic or difficult such as a death, divorce, or accidents? If so, please describe: \_\_\_\_\_  
\_\_\_\_\_

Does your child have any special needs, physical handicaps, speech problems or learning disabilities we should be aware of? \_\_\_\_\_  
\_\_\_\_\_

Previous preschool or daycare experience? Yes \_\_\_\_ No \_\_\_\_

Goals for your child's social skills? (please circle all that apply)

Sharing, manners, taking turns, listen and follow directions/rules, follow routines, work independently, good friend, good sport, takes care of materials and environment, eats independently, personal hygiene, independent toileting, conflict resolution, self-control, self-confidence, other: \_\_\_\_\_

Goals for your child's cognitive skills? (please circle all that apply)

Number, letter & shape recognition, reading words and books, names colors, able to write their own name, able to problem solve, other: \_\_\_\_\_

Is your child involved in extra-curricular activities? Yes \_\_\_\_ No \_\_\_\_

How many hours a day does your child watch T.V, or use technology, (i.e. tablet, phone, computer) \_\_\_\_\_

How do you discipline? \_\_\_\_\_

Is your child on a daily schedule/routine? \_\_\_\_\_

When did your child begin talking? \_\_\_\_\_

When is your child's bedtime? \_\_\_\_\_ How many hours of sleep? \_\_\_\_\_

Does your child play video games? \_\_\_\_ If so, are they educational? \_\_\_\_\_

Does your child have special names for personal objects? \_\_\_\_\_

Does your child nap? Yes \_\_\_\_ No \_\_\_\_ If so, how long? \_\_\_\_\_

What are your expectations for your child at Our Montessori School this year?

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Are you interested in volunteer opportunities at OMS? Yes \_\_\_\_ No \_\_\_\_

If yes, in what capacity?

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Would you be interested in sharing information about your family's culture or background? Yes \_\_\_\_ No \_\_\_\_

If yes, please describe:

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Any additional information you would like to share with us about your child or family?

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\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Parent/Guardian Signature