



## St. Joseph School Application

**Answers to the following questions will help your child's teacher to be prepared at the beginning of your son's/daughter's experience at St. Joseph School.**

Name of Child \_\_\_\_\_ Sex \_\_\_\_\_ Birthdate \_\_\_\_\_

Address \_\_\_\_\_

Telephone Number \_\_\_\_\_ Cell Number \_\_\_\_\_

Names of Parents (or Guardian) \_\_\_\_\_

If Guardian, what is your relationship to the child? \_\_\_\_\_

Names and ages of siblings \_\_\_\_\_

Language spoken: \_\_\_\_\_ English \_\_\_\_\_ Other; please indicate: \_\_\_\_\_

Date of St. Joseph Parish Baptism: \_\_\_\_\_ (if baptized at other parish, please attach copy of baptismal certificate)

1. Has the child had preschool, Kindergarten or play class experience? \_\_\_\_\_ Yes \_\_\_\_\_ No  
Where \_\_\_\_\_ Date \_\_\_\_\_ How Long \_\_\_\_\_
2. Are there persons other than parents and siblings living in the home? \_\_\_\_\_ Yes \_\_\_\_\_ No  
Who? \_\_\_\_\_
3. Father's Occupation \_\_\_\_\_ Mother's Occupation \_\_\_\_\_
4. Has there been anything unusual in the home or the family situation such as divorce, family deaths, family illness, frequent moving, etc.? \_\_\_\_\_
5. For which hand does your child show a preference? \_\_\_\_\_ Left \_\_\_\_\_ Right \_\_\_\_\_ Ambidextrous
6. What special interests does your child have? \_\_\_\_\_  
\_\_\_\_\_
7. Do you feel your child will need any special help in these areas?  
\_\_\_\_\_ Hearing \_\_\_\_\_ Vision \_\_\_\_\_ Speech
8. Has your child participated in the Downers Grove Public Schools Preschool Screening Program?  
\_\_\_\_\_ Yes \_\_\_\_\_ No
9. Are there any conditions to be watched for in school? \_\_\_\_\_ Yes \_\_\_\_\_ No
10. Is your child on any medication? \_\_\_\_\_ Yes \_\_\_\_\_ No If yes, please describe: \_\_\_\_\_

11. Is your child under treatment for any special conditions?  Yes  No

If yes, please describe: \_\_\_\_\_

12. Please indicate if you have concerns with:

Elimination

Allergies

Frequent nosebleeds

Hay fever

Sinus

Hyperactivity

Asthma

Other: \_\_\_\_\_

13. Has the child ever been hospitalized?  Yes  No

For what? \_\_\_\_\_ For how long? \_\_\_\_\_

14. Are your child's playmates:  Older  Younger  Same age

15. Do you read to your child daily?  Yes  No

16. Do you go on family outings?  Yes  No Where? \_\_\_\_\_

17. How does your child share in family responsibilities? \_\_\_\_\_

18. What regular TV programs does your child watch? \_\_\_\_\_

19. Approximate bedtime: \_\_\_\_\_

20. What have you found to be an effective means of disciplining your child? \_\_\_\_\_

21. Does your child:

Put on coat and boots?  Yes  No

Tie own shoe laces?  Yes  No

Take care of toilet needs?  Yes  No

Know name and address?  Yes  No

Know phone number?  Yes  No

22. What is your child's attitude toward starting school this year? \_\_\_\_\_

\_\_\_\_\_

23. Is your child afraid of any of the following:

Dark

Being alone

Strangers (nurses, etc.)

Strange animals

Making mistakes

Other: \_\_\_\_\_

24. Person to call in case of emergency: \_\_\_\_\_ Number \_\_\_\_\_

25. Would you be able to assist the Kindergarten teacher during the year?  Yes  No

If yes, please explain interests: \_\_\_\_\_

26. Has your child ever received special education in preschool?  Yes  No

If yes, please explain: \_\_\_\_\_