Trinity Lutheran School

20 East Salzburg Road
Bay City, MI 48706
(989)662-4891

Date: ____________________

Child's Name: ____

Address: _____________________________ City: ________________________Zip: _______

Phone: _______________________________ Birthdate: ______________________________

Place of Birth: ____

Father's Name: ________________________ Mother's Name: _________________________

Father's Place of Employment: ____

Mother's Place of Employment: ____

Emergency Name: ____

Emergency Number: ____

Hospital Choice: ____

Physician's Name: ____

Church Affiliation: ____

Where will your child go after school? ____

Name: ____

Address: ________________________________ Phone: ________________________

Preschool children in family other than above child:

Name	Sex	Birthdate
1.		
2.		
3.		

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Date Enrolled ____________________

Grade __________________________

Legal Name
Of Child ____ Nickname ___________
Last First Middle

Address ____
Number Direction Street/Road City Zip Code

Home telephone # ____________ Unlisted? ______ (For school use only!)

Date of Birth: Month __________ Day __________ Year __________ Age __________

Place of Birth: City ____________________ County ____________________ State _________

If Adopted, at what age? ____________________ Sex: _____ Male _____Female

Racial Ethnicity: (Circle one) American Indian African American Asian Hispanic
White Other

_______________________ ____ _____
Name of school last attended Address of school Grade

Names of other children in family: Age Grade Birthdate

_____________________________________ _____ _____ _______________

_____________________________________ _____ _____ _______________

_____________________________________ _____ _____ _______________

_____________________________________ _____ _____ _______________

Family Data	Mother	Father
Name		
Place of Birth		
Place of Employment		
Education Status	Elem HS College	Elem HS College
Marital Status		
Step-Parent / Guardian		
With Whom Does Child Reside		

Revised 9/2009

Has your child had experience with groups of children in:	Yes	No
Neighborhood?	_____	_____
Sunday or Bible School?	_____	_____
Nursery or Preschool?	_____	_____
Where? ____		
Daycare?	_____	_____
Where? ____		
Library Story Hour?	_____	_____
Group Instruction?	_____	_____

Please describe any problems which occurred:
____

How long will your child play by himself with a favorite toy?

1 to 5 minutes _____ 6 to 15 minutes _____ 16 to 30 minutes _____

About how long does your child sit and watch television each day? _______________________

What types of programs does he/she prefer?
____

Can your child:	Yes	No
Pay attention to a short story when it is read and answer simple questions about it?	_____	_____
Draw and color beyond a simple scribble?	_____	_____
Tie his/her shoes?	_____	_____
Zip or button up his/her coat/pants?	_____	_____
Alternate feet walking downstairs?	_____	_____
Walk a straight line?	_____	_____
Fasten buttons he/she can see?	_____	_____
Use a knife for spreading jam or butter?	_____	_____
Take care of his/her toilet needs by himself/herself?	_____	_____
Be away from you two or three hours without being upset?	_____	_____

Health and Behavior Record

Check any of the following that may apply to your child:

1	Anemic ______________	5	Diabetes _____________	9	Kidney Problems ______
2	Allergies _____________	6	Easy Bleeder __________	10	Rheumatic Fever ______
3	Asthma ______________	7	Epilepsy _____________	11	Tonsillitis ____________
4	Convulsions __________	8	Frequent Colds ________	12	Other ________________

Is this child on any long term medication? _____ Yes _____ No If Yes, What? ________

Is your child right-handed? _____ Is your child left-handed? _____

- - - -

Please check any of the following that, in your opinion, will help us to better understand your child.

Health

1 May Engage in:
_____ Normal Activity
_____ Restricted Activity
2 _____ Overweight
3 Sleep Habits:
_____ Good
_____ Poor
4 Eating Habits:
_____ Good
_____ Poor
5 General Health:
_____ Good
_____ Poor
6 Other Health Problems:
____

Behavior Traits

1 _____ Temper Tantrums
2 _____ Friendly
3 _____ Stubborn
4 _____ Talkative
5 _____ Easily Disturbed
6 Relates to Others:
_____ Good
_____ Poor
7 _____ Nervous
8 _____ Anxious
9 _____ Overactive
10 _____ Withdrawn
11 _____ Fears

Maturity

1 Coordination:
_____ Good
_____ Poor
2 Physical Size:
_____ Over
_____ Under
3 Speech:
_____ Good
_____ Poor
4 Independent:
_____ Good
_____ Poor
5 Shares with Others:
_____ Good
_____ Poor

Does your child have any allergies to any types of food? ______________________________
If so, what are they? ____

Does your child have any types of fears? ____
If so, what are they? ____

Is there anything else that I should know about your child? _____________________________