



Primary Questionnaire

Student Name: _____

Birth Date: _____ Today's Date: _____

In order to get to know your child better we ask that you fill out this form and return it with your application.

General Information

Primary language spoken at home: _____

Mother's occupation: _____

Mother's place of business: _____

How many hours per day does mom work? _____ How often is mom out of town? _____

Father's occupation: _____

Father's place of business: _____

How many hours per day does dad work? _____ How often is dad out of town? _____

Health Information

Was your child adopted? Yes No

What illnesses has your child had? _____

Highest fever? _____ How long did it last? _____

Does your child have any allergies? * Yes No If yes, what kind? _____

Does the allergy require maintaining an EPI Pen or other medications at school? * Yes No

Does your child have any medical condition that requires immediate access to medication or a specific response from staff? * Yes No

Is your child sun sensitive? Yes No Number of days ill last year? _____

How old was your child when he/she first walked? _____ Did your child crawl before walking? Yes No

Age when first words were spoken? _____

Describe toilet training: _____

Is your child taking any daily medications? Yes No When, and for how long? _____

Does your child have any vision or hearing problems? Yes No If so, explain _____

Does your child nap? Yes No When, and for how long? _____

Did your child have frequent ear infections? Yes No Tubes? Yes No

*** Upon acceptance you will be provided with a form to share more detailed information.**

Family and Childcare Information

Does your child have any siblings? Yes No

Name	Age	Describe Relationship

Parents' marital status: _____

With whom does your child live? _____

Likes and Dislikes

What does your child enjoy doing most? _____

What activities does your family enjoy doing together? _____

Does your child prefer to play alone or with playmates? _____

When playing with playmates, how does your child react to conflict (words, crying, hitting, passive, etc)

What are the names and ages of your child's playmates?

Name	Age

Describe any other school or group situation in which your child has participated and for how long.

Age	Name of School	Describe

Which situation did your child like most and why? _____

Please describe, if any, difficulties that your child may have had in another school or group setting?

Routines (it would help us to have an idea of our child's typical day)

Meals:

Are meals at a set time? Yes No Where are meals eaten? _____

Are meals with adults? Yes No

Bedtime:

What time does our child go to bed? _____ What time does your child wake up? _____

Does your child sleep through the night? Yes No Is your child prone to nightmares? Yes No

Please describe your bedtime process _____

Please describe your morning routine: (T.V., breakfast, dressing routine, etc.)

In what ways do you encourage independence in your child? _____

Does your child have any chores? Yes No If yes, please describe: _____

On average how many hours of T.V. does your child watch per day? _____

Miscellaneous

Are you aware that the Montessori program is based on a 3-year cycle? Yes No

Are you aware that Villa Montessori School requests each family to volunteer ten hours of time, per year? Yes No

Do you have any special talents that you would like to share with Villa? Yes No

If yes, what? _____

What brought you to Villa Montessori? _____

What are your goals for your child this year? _____

Are there any other comments that you feel would be helpful? _____
