



SPRING HILL
S C H O O L

Confidential Child History

Dear Parent(s),

Our education addresses not only academic needs, but the needs of the whole child as well. This questionnaire is meant to assist us in establishing a deeper understanding of the growth and development of your child. The early years are so important in the development of human capabilities that we ask you to be as conscientious as possible when filling out this form. The information will be handled confidentially. Thank you very much for your cooperation.

-the Faculty of Spring Hill School

General Information

Date: _____

Child's Full Name: _____

Date of Birth: _____

Siblings/Ages: _____

Who is presently living in the home?

History of Early Years (If your child is adopted, please fill out available information.)

Pregnancy

Was the pregnancy unusual in any way? _____

Before birth was there any: (circle)

Maternal malnutrition Toxemia Bleeding Smoking Drugs/Alcohol

Accidents: _____

Infectious Disease: _____

Were there any major events in the family life during the pregnancy?

Birth

In the hospital or at home? _____

What were the circumstances like:

During birth was there any: (circle)

Prematurity Postmaturity Cord around neck Breech delivery Rapid delivery

Cesarean with prior labor Scheduled Cesarean Drugs during labor _____

Fetal monitoring (please specify): Internal External

How did you come to choose the name for your child?

Infancy

Was your child breast or bottle fed? _____ For how long? _____

When did your child first sit unassisted? _____

How and when did the process of learning to speak evolve?

With crawling, did your infant propel self on abdomen? _____

Began crawling on hands and knees at _____ months for _____ months.

Used a Baby Walker Bouncer Carried often Used playpen: often/seldom/not at all

Did infant propel self on seat of pants? _____

Age of first teeth: _____

Have both parents worked since the child's birth? (Explain) _____

How much time does the child spend in the care of people other than the parents? _____

With whom? _____

Health

- 1. Does your child seem well most of the time? Yes _____ No _____
- 2. In a year, does your child usually have more than 3 colds or sore throat infections with a fever? Yes _____ No _____
- 3. Does your child have trouble getting rid of severe coughs? Yes _____ No _____
- 4. Does your child complain frequently of headache, leg ache, stomachache or any other pain? Yes _____ No _____
- 5. Has your child had trouble with his/her eyes or vision? Yes _____ No _____
- 6. Is your child taking any medications now? Yes _____ No _____

If yes, what medications? _____

Why? _____

7. Does your child have allergies? Yes _____ No _____

Describe reactions and medications, if any: _____

8. PAST HISTORY – Circle any the child has had

- | | | |
|--------------------------|----------------------------|-----------------------------|
| “Red” or “Hard” measles | Diabetes | Heart Trouble |
| German or 13-day measles | Pneumonia | Kidney or bladder infection |
| Mumps | Premature birth | Convulsions, seizures, fits |
| Chicken Pox | Trouble breathing at birth | Physical handicaps |
| Meningitis | Birth injury or defect | |
| Scarlet Fever | Head injury | |
- High fever (above 104 for three days or more)
- Allergies (eczema, hives, drug or food intolerance, hay fever, wheezing, asthma)

9. RECENT HISTORY – Circle any the child has had recently

- | | |
|------------------------------|----------------------------|
| Frequent urination | Dizziness, fainting spells |
| Small stream or dribbling | Tires easily |
| Burning or painful urination | Swollen glands |
| Constant cold | Shortness of breath |
| Bowel problems | Difficulty breathing |
| Bleed easily | Joint pain |

10. Any other illnesses or diseases? Yes _____ No _____

If yes, what? _____

Habit Life

(Check those that apply)

Eating: Good appetite _____ Disinterested _____ Cravings _____ Light Eater _____
Tendency towards: Sweet _____ Sour _____ Bitter _____ Salty _____

Any food restrictions? _____

Sleeping: How many hours per night? _____ Nap? _____ How long? _____
Falls asleep easily _____ Restless _____ Dreamer _____ Awakens slowly _____

Sleepwalking (Age(s))? _____

Bedwetting? _____

Wetting during the day? _____

Prior to registration, all families are made aware that our school strives to be an environment free from the effects of movies, computers, television, and video games. We ask that children refrain from the use of media at least during the school week. We understand that this is difficult for some families, but we have all experienced first hand how the media can really have a negative impact on the entire classroom when introduced by even a few children.

TV/VCR

Movies

(Past) Hours per Week:

(Present) Hours per Week:

What is your current position regarding TV viewing?

Are you willing to eliminate TV viewing during the week?

How can teachers or other parents help you understand the importance of limited media exposure and help this ideal become a reality? (Can we offer you articles, parent/teacher conferences, a parent support person, lectures from the outside community, new playmate situations?)

Social Life

Have there been any important changes in your child's life? (i.e. moving, deaths, divorce, shocks, accidents, etc.)

What is your child's favorite way to spend time?

Are there any activity restrictions?

How much time does your child spend with each parent and what kinds of activities?

Does the child tend to be outgoing or reserved?

What is your child's relationship to other children in your neighborhood?

... to brothers and/or sisters?

What type of discipline works best for your child?

Have any of the following been recommended for your child?

Testing for learning differences? _____

Psychological testing or counseling? _____

Testing regarding any behavioral problems? _____

Comments:

Please share with us any religious preference you may have:

What do you know about Waldorf Education?

Additional paper may be used if more room is needed for comments.

I acknowledge that the information I have given in the questionnaire is complete and correct.

Parent Signature

Date

Parent Signature

Date

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Spring Hill School welcomes children of all racial, social and religious backgrounds.

