

FOR OFFICE USE ONLY

DATE RECEIVED

____/____/____



HURLBUTT ELEMENTARY SCHOOL
2020-21 PRESCHOOL APPLICATION

Date of Application: ____/____/____

Child's Name: _____

Child's Address: _____

Male Female

Date of Birth: ____/____/____

Child age as of 9/1/2020: _____

Parent/Guardian 1: _____

Parent/Guardian 1 E-mail Address: _____

Parent/Guardian 1 Address: _____

Telephone: Home: (_____) _____ Work: (_____) _____

Cell: (_____) _____

Parent/Guardian 2: _____

Parent/Guardian 2 E-mail Address: _____

Parent/Guardian 2 Address: _____

Telephone: Home: (_____) _____ Work: (_____) _____

Cell: (_____) _____

FAMILY

	Name	Age	Male/Female
Parent/Guardian 1:	_____	N/A	<input type="checkbox"/> Male <input type="checkbox"/> Female
Parent/Guardian 2:	_____	N/A	<input type="checkbox"/> Male <input type="checkbox"/> Female
Sibling:	_____	_____	<input type="checkbox"/> Male <input type="checkbox"/> Female
Sibling:	_____	_____	<input type="checkbox"/> Male <input type="checkbox"/> Female
Sibling:	_____	_____	<input type="checkbox"/> Male <input type="checkbox"/> Female
Sibling:	_____	_____	<input type="checkbox"/> Male <input type="checkbox"/> Female
Sibling:	_____	_____	<input type="checkbox"/> Male <input type="checkbox"/> Female
Sibling:	_____	_____	<input type="checkbox"/> Male <input type="checkbox"/> Female

Has any family member attended Preschool Early Learning Center? YES NO

Has your child been evaluated or received services from Birth to Three or any other early
childhood agency? YES NO

If yes, please explain:

Did your child ever attend Nursery School?

YES

NO

If yes, please provide name of school, length of class time (e.g., 2-hours a day) and how often
e.g., 3x a week):

If your child did attend Nursery School, tell us about your child's reaction to the school
experience:

Does your child suffer from separation difficulties?

YES

NO

If yes, please explain:

HEALTH

Does your child have any allergies? (peanut, bee stings, food, etc.?) YES NO

If yes, please explain:

Does your child have any strong fears or anxieties? YES NO

If yes, please explain:

Does your child take any medication on a regular basis? YES NO

If yes, which medications?

Does your child have a history of ear infections?

YES

NO

If yes, how many, when?

Please explain any significant medical history:

SELF-HELP SKILLS

Can your child use a spoon and fork?

YES

NO

Can your child wash and dry his/her hands?

YES

NO

Does your child need assistance with eating?

YES

NO

Can your child assist with dressing himself/herself?

YES

NO

Do you have any concerns about your child's gross or fine motor skills?

YES

NO

Please explain if necessary:

TOILETING*

Does your child wear a diaper/pull-up? YES NO

Is your child toilet trained? YES NO

If yes, does your child use the bathroom independently? YES NO

Please explain, in detail, where your child is in the toileting process.

****Peer models must be toilet trained prior to entering the Early Learning Center program. This information will be carefully considered when reviewing applications***

SOCIAL DEVELOPMENT

	ALWAYS	SOMETIMES	NEVER
Sticks to one activity (listens to story, table top activities) for at least 10 minutes at a time)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Accepts limits without getting upset	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Plays with toys without breaking them	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Plays well with other children (takes turns, shares)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stops an activity when parents say to do so	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Keeps working at something until it is finished	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is well liked by other children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does what parents ask him/her to do	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Waits his/her turn in games	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Overreacts or has temper tantrums	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Uses words rather than physical actions to settle arguments with other children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reacts in ways parents can predict	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Admits mistakes and doesn't blame others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is easily frustrated	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Describes others' feelings (happy, sad, mad)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Smiles, giggles, laughs in response to something funny	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Waits to hear the entire question before answering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Goes to bed easily without a struggle	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asks permission to use something that belongs to someone else	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SPEECH AND LANGUAGE DEVELOPMENT

- Can other adults understand your child? YES NO
- Can your child's peers understand him/her? YES NO
- Does your child ask for help when needed? YES NO
- Does your child exhibit frustration when expressing himself/herself? YES NO
- Does your child ask who, what, where and why questions? YES NO

OTHER INFORMATION

Please tell us anything else you feel is important for us to know about your child.

SIGNATURE & DATE

Parent/Guardian Signature: _____

Print Name: _____

Date: ____/____/____