

Please include the ff with completed forms
Copy of both parents id's.
Copy of Child's birth certificate & clinic card.



Smiley Kids Sandton
Pre-Primary School



Exclusive Baby, Pre-Primary and Aftercare Centre

Hurlywood Trading 52 cc t/a Smiley Kids Sandton



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CONFIDENTIAL QUESTIONNAIRE
Please complete this form as comprehensively as possible

Full name of child			
Name by which child is known			
Date of Birth		Religion	
Father's full name		Father's occupation	
Mother's full name		Mother's occupation	
Father's car registration		Mother's car registration	
Marital Status		Is your child adopted?	
Number of children in family		Child's position in family	of
Is your child a stepchild?		If yes does your child have a good relationship with his/her step parent?	
Do you have other stepchildren?		Names and ages of other siblings in the family	
If yes, list names and ages			
If divorced, what is your child's relationship like with his/her other parent?			
Do you have a family history of learning problems, such as hyperactivity, minimal brain dysfunction or any other learning problem? If yes, please provide details.			
What form of discipline do you implement at home? Please provide details. What form of discipline have you found to be most effective?			
Does your child respond favorably to this parental discipline?			
Name of school / playgroup previously attended			
Number of years at previous school/playgroup		Were he / she happy at the previous school?	
If not what were some of the difficulties or challenges he/she faced at the last school / playgroup?			
How did you hear about Smiley Kids Sandton Pre-Primary School?			
Has your child ever been assessed by?		If yes, please provide the person's name	
Psychologist		Please provide copies of any reports or test results you have received	
Remedial Therapist			
Occupational Therapist			
Speech Therapist			
Speech: Does your child ever?		Which phrase best describes your child's	

Stammer		ability to communicate with you?	
Lisp		Which languages is your child exposed to on a regular basis in your home environment?	
Stutter			
Use baby language			

Toilet Habits	Can he/she go to the toilet on his/her own?		Is he/she completely potty-trained?	
	Is he/she prone to the occasional accident?		Does he/she wear a nappy at night?	

Eating Habits	Does he/she feed him/herself?		Can he/she use a spoon?	
	Has he/she given up his/her dummy?		Can he/she use a fork?	
	Has he/she given up his/her bottle?		Can he/she use a knife?	

General	Is he/she right or left-handed?		Can he/she dress him/herself?	
	Can he/she button clothes?		Can he/she tie shoe laces?	
	Does he/she have a special toy?		Do you have a garden?	
	Has he/she ever had his/her eyes tested?		Has he/she ever had a hearing test?	
	Were there any problems?		Were there any problems?	
	Does your child wear glasses?		Does your child have grommets?	
	Does your child wear a hearing aid?		How many times has your child had grommets fitted?	
	If yes, please explain:		When the last one was inserted?	
	Does your child have any other physical problems that could affect his/her learning potential?			
	Please explain if you answered yes			

Allergies	Does your child suffer from any of these allergies?		Provide details of reaction and treatment required	
	Bee stings	<input type="checkbox"/>		
	Analgesics	<input type="checkbox"/>		
	Insect bites	<input type="checkbox"/>		
	Anti-biotic	<input type="checkbox"/>		
	Foods	<input type="checkbox"/>		
	Food colorants	<input type="checkbox"/>		
	Food additives	<input type="checkbox"/>		
	Other ()	<input type="checkbox"/>		
If your child requires medicine to treat any allergic condition, please leave a supply of it in the First Aid cupboard at school. Full instructions must be attached.				

Asthma	Is your child asthmatic?		What treatment is given?	
	What brings on an attack?			
If your child requires medicine to treat any asthmatic condition, please leave a supply of it in the First Aid cupboard at school. Full instructions must be attached.				

Operations and Illnesses	Has your child ever undergone surgery? If yes, please provide details of all operations				
	Date	Details		Length of Stay	
	Was your child accompanied by a parent/guardian on a 'live-in' basis for any hospital stay?				
	Do you feel your child suffered any serious emotional upset due to the stay in hospital?				
	If yes, please provide details				
	Has your child ever contracted one of these illnesses? Please tick each applicable block				Please indicate if your child is up to date with the following inoculations. Please check your child's clinic card.
	Croup	<input type="checkbox"/>	Chicken Pox	<input type="checkbox"/>	
	German Measles	<input type="checkbox"/>	Scarlet Fever	<input type="checkbox"/>	
Measles	<input type="checkbox"/>	Whooping Cough	<input type="checkbox"/>		
BCG		<input type="checkbox"/>	Polio	<input type="checkbox"/>	
Diphtheria		<input type="checkbox"/>	Measles	<input type="checkbox"/>	

	Mumps	<input type="checkbox"/>	Meningitis	<input type="checkbox"/>	Tetanus	<input type="checkbox"/>	Mumps	<input type="checkbox"/>
	Encephalitis	<input type="checkbox"/>	Ear Infection	<input type="checkbox"/>	Whooping Cough	<input type="checkbox"/>	German Measles	<input type="checkbox"/>
	Eye Infection	<input type="checkbox"/>	Urinary Infection	<input type="checkbox"/>	Has your child ever broken a limb?			<input type="checkbox"/>
	If yes, please provide details:							
	Does your child have any other physical handicap, congenital or other illness / condition? <input type="checkbox"/>							
	If yes, please provide details:							
Pregnancy and Birth	Did you experience any problems during your pregnancy? <input type="checkbox"/>							
	If yes, please provide details:							
	Was your child:				What was your child's APGAR score at birth and after 5 minutes?			
	Born on due date?	<input type="checkbox"/>						
	Premature?	<input type="checkbox"/>	By how many days?		Was your child placed in Pediatric ICU at birth? <input type="checkbox"/>			
	Overdue?	<input type="checkbox"/>	By how many days					
	Delivered Naturally?	<input type="checkbox"/>	Delivered by caesarean?	<input type="checkbox"/>	If yes, please provide details:			
	Delivered by forceps?	<input type="checkbox"/>	Other ()	<input type="checkbox"/>				
	Was your child:							
	Treated for jaundice?	<input type="checkbox"/>	Breathing problems?	<input type="checkbox"/>	Why was it necessary to place the child in an incubator? <input type="checkbox"/>			
	Placed in an incubator?	<input type="checkbox"/>	For how many days?					
	Breast fed?	<input type="checkbox"/>	For how long?		Did your child experience-feeding problems? <input type="checkbox"/>			
	Bottle fed?	<input type="checkbox"/>	For how long		If yes, please provide details:			
	Circumcised (if a boy)	<input type="checkbox"/>	At what age?					
Colicky?	<input type="checkbox"/>	For how long?						
If other problems, please provide details:								
Developmental Milestones	At what age did you child:				Is there anything else that you think we ought to know about your child?			
	Sit up?		Stand?					
	Crawl?		Walk?					
	Talk?		Become fully potty trained?					
			(Day and night dry)					

Thank you for taking the time to complete this questionnaire. We appreciate that some of the questions are of a personal nature, but the answers will help us to deal with your child in a more sympathetic and understanding manner.

Completed by: _____ Date: _____ /20