

# NEW MILFORD PUBLIC SCHOOLS

## Over the Moon Preschool Program

### **Additional Information Required**

Child's Name (first, middle, last) \_\_\_\_\_

Date of Birth \_\_\_\_\_ Male or Female (circle one)

Address \_\_\_\_\_

Home Telephone Number \_\_\_\_\_ E-Mail Address \_\_\_\_\_

### **Family Information**

List any other adults in the family living at home and their relationship to your child (grandparents, aunts/uncles, nannies, etc.)

\_\_\_\_\_  
\_\_\_\_\_

### **School/Group Experience**

Has your child had other group experiences with young children? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please list (library, swim classes, play groups, etc.)

\_\_\_\_\_

Will your child be attending another school while attending the Over the Moon Program? Yes \_\_\_ No \_\_\_

If yes, please indicate the name of the school \_\_\_\_\_

Also please provide the days and times \_\_\_\_\_

**Medical Information and Religious Restrictions**

Is your child allergic to any foods? No \_\_\_\_\_ Yes (please list) \_\_\_\_\_

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(If your child requires any medication(s) or an Epipen to be administered during school, please have your child's Physician complete the Emergency Health Care Plan form and parents must provide an Epipen/Benadryl).

Are there any foods to be avoided in school, either due to allergy or religious restrictions? Please specify:

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Does your child have any other allergies (for example, bee stings, latex, animal hair)? No \_\_\_\_\_

Yes (please list) \_\_\_\_\_

**Behavioral Information**

Does your child have any particular fears or sensitivity to loud noises? Please describe.

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**Unless there is a documented, pre-existing medical condition, all Over the Moon children must be fully toilet-trained and to care for their toileting needs independently.**

Is your child toilet-trained? Yes \_\_\_\_\_ No \_\_\_\_\_ Training in Process \_\_\_\_\_

How does your child express his/her need to use the bathroom? Please write the word your child will say for: Urinate \_\_\_\_\_ Bowel Movement \_\_\_\_\_ Vomit \_\_\_\_\_

Have you left your child in another's care? No \_\_\_\_\_ If yes, who? Grandparent \_\_\_\_\_

Relative \_\_\_\_\_ Adult friend / Neighbor \_\_\_\_\_ Teen babysitter \_\_\_\_\_

Does your child have any difficulties separating from parents/guardians? Yes \_\_\_ No \_\_\_ Sometimes \_\_\_

How does your child act when you leave him/her? Cries \_\_\_\_\_ Withdraws \_\_\_\_\_ Tantrum \_\_\_\_\_

Other (please specify) \_\_\_\_\_

Does your child have any particular habits or mannerisms such as thumb-sucking, nail biting, etc.?

No \_\_\_\_\_ Yes (please describe) \_\_\_\_\_

Does your child have speech difficulties? No \_\_\_\_\_ Yes (please describe) \_\_\_\_\_

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### **Interests of Child and Family**

In the interest of learning about the cultural diversity of our community, we encourage family members to share aspects of their cultural heritage with their child's class. Some examples include holiday traditions, foods, costumes, dance, music/musical instruments, language and storytelling. Would you be interested in sharing your family's culture with your child's class at school? Yes \_\_\_\_\_ No \_\_\_\_\_

What is your family's cultural background? \_\_\_\_\_

If you speak a language other than English, would you be willing to help us communicate with non-English speaking Over the Moon families who speak your language?

Yes (please specify language) \_\_\_\_\_ No \_\_\_\_\_

**Thank you for completing this form and providing us with this important information about your child and family. We look forward to your participation in the Over the Moon program.**