

Shepherd Valley Waldorf School

EDUCATING CHILDREN • CULTIVATING COMMUNITY • ENVIRONMENTAL STEWARDSHIP

Pre-K/Kindergarten Application & Child Background

Please submit with \$40 Fee

Please select one option:

5-Day Morning (8:30 am - 12:30 pm)

5-Day with Afternoon Care (to 3:20 pm)

5-day
options are
for ages 4-6

3-Day (Wed. - Fri.)

The 3-day
option is for
ages 3 & 4

Please attach a photograph of your child (& family if available)

Date/Year Requesting to enroll: _____

Name of Child: _____ Date of Birth: _____

How did you hear about Shepherd Valley Waldorf School?: _____

Father's Name: _____ Mother's Name: _____

Father's Address: _____ Mother's Address: _____

City: _____ State: _____ Zip: _____ City: _____ State: _____ Zip: _____

Father's Home #: _____ Mother's Home #: _____

Father's Work #: _____ Mother's Work #: _____

Father's Cell #: _____ Mother's Cell #: _____

Father's email: _____ Mother's email: _____

Parent's marital status: _____

What are you hoping to find in Waldorf Education for your child?: _____

To what other schools have you applied?: _____

STUDENT BIOGRAPHY

How was the pregnancy? _____

Circle: Hospital or Homebirth. Family/Friends Present?: _____

If your child was adopted, at what age and circumstances?: _____

Approx. Weight at Birth?: _____ Was Child breastfed? **YES NO** Until what age?: _____

Did Child crawl? **YES NO** Did Child use a walker? **YES NO** "Johnny Jump-up?" **YES NO**

At what age did Child walk?: _____ Speak?: _____ When was Child toilet trained?: _____

Does Child wet bed? **YES NO** Does Child suck thumb or fingers/clothing?: _____

Does Child have any other habits? (i.e. bite nails, suck, twist hair, etc.): _____

Has Child been to a dentist? **YES NO** Any Cavities? **YES NO**

Has child changed residences? If so, when and how?: _____

Preschools/Homegroups/or Kindergartens currently attending?: _____

Preschools/Homegroups/or Kindergartens previously attended?: _____

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MEDICAL HISTORY

Does your child wear glasses? **YES NO** How long has s/he been wearing them?: _____

When do the glasses need to be worn?: _____

Please describe any hearing difficulties.: _____

Please describe any speech difficulties.: _____

Are there any letters or sounds that your child does not yet speak clearly? (Such as R, Y, D): _____

Please describe any dental difficulties.: _____

Please describe any allergies.: _____ What is your child's reaction?: _____

Please describe any injuries or surgical operations.: _____

When your child becomes ill, how is the illness handled? (traditional-antibiotics,etc., homeopathically): _____

Please list any academic/social-psychological evaluations that your child has experienced.: _____

Please list name, address & phone #'s of resources for above evaluations: _____

May we have permission to call the above resources?: **YES NO**

HOME AND FAMILY LIFE

Please describe your child's primary residence. (Who lives there, names and ages of other children/step children, name of stepparent): _____

If applicable, please describe the secondary residence. (Who lives there, names and ages of other children/step children, name of stepparent, custody arrangements, and regular routine for visitation.): _____

What language is spoken at home?: _____ by mother?: _____ by father?: _____

What languages does your child speak?: _____

What time does Child awaken on weekdays?: _____ Weekends?: _____

How does Child awaken? (Dreamy, cheery, grumpy): _____

What, if any, is the bedtime ritual?: _____

Does Child fall asleep easily? **YES NO** Does he/she sleep through the night? **YES NO**

Any history of recurring dreams or nightmares?: **YES NO** _____

Does your child and/or other family members follow a special diet?: **YES NO** _____

What meals does the Child eat with the entire family?: _____ What times?: _____

Please describe regular chores your child may have.: _____

Does Child nap daily? **YES NO** At what time? _____ How long? _____

How do you discipline your Child? (example): _____

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HOME AND FAMILY LIFE (continued)

How would you describe your Child's temperament?: _____

Please describe any fears or anxieties that your child has.: _____

PLAY

Describe how your family spends time together.: _____

Does your child play sports? Describe: _____

Does your child attend classes (i.e., dance, music, etc.)?: _____

Does Child watch television? **YES NO** When?: _____ What?: _____

How Long?: _____ Does Child play on the computer? **YES NO** Nintendo? **YES NO**

What kind of music do you and your Child listen to at home?: _____

Do you play the radio or tapes in the car? **YES NO** Which?: _____

Does Child have pets?: _____ Does Child have imaginary playmates?: _____

Give names and describe: _____

Does Child enjoy playing alone? **YES NO** Describe: _____

Does Child have special doll or toy?: _____

What kind of play does Child enjoy most?: _____

What kind of play does Child enjoy least?: _____

Any other comments for the teacher to be aware of: _____

Referred by Current Shepherd Valley Waldorf family? **YES NO**

If so, please indicate name of family: _____

Parent's Signature: _____ Date: _____

Parent's Signature: _____ Date: _____

Shepherd Valley Waldorf School does not discriminate on the basis of race, religion, or national origin in its admission policy or the conduct of its education programs.