

# Early Childhood Center Level 2

## 4 year old applicants

Please complete this form in ENGLISH

Please answer all the questions honestly. This information will help us to have a better understanding of your child before the assessment.

Family Name		First Name	
Date of Birth	YYYY / MM / DD	Preferred name	
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female		
Nationality		Home Language	
Is your child able to dress independently?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Does your child sleep in the afternoon?	<input type="checkbox"/> Never <input type="checkbox"/> Sometimes <input type="checkbox"/> Every day - For how long? _____		
What does your child enjoy playing with?			
Does your child have a favorite toy?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, what is it?	
Do they take the toy to bed?	At night? <input type="checkbox"/> Yes <input type="checkbox"/> No	During the daytime sleep?	<input type="checkbox"/> Yes <input type="checkbox"/> No
What does your child most like to eat?		What does your child not like to eat?	
Is there anything your child is afraid of?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, what?	
What are the names and ages of other children in your family?			
Does your child get angry or upset often? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what is usually the cause of that anger or upset?		Does your child display any behaviour that causes you concern? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain:	
How much English does your child speak?		<input type="checkbox"/> None <input type="checkbox"/> A little <input type="checkbox"/> Some <input type="checkbox"/> Speaks English very well	
Can your child understand instructions in English?		<input type="checkbox"/> A few <input type="checkbox"/> Many <input type="checkbox"/> Understands all English instructions	
Give 5 examples of English instructions that your child understands?			
When would you like your child to attend ECC 4?		<input type="checkbox"/> Half day <input type="checkbox"/> Full day	
Does your child have any allergies?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, what are they allergic to?	
Does your child have any medical conditions?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, what is the condition?	
Does your child have an English name?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If so, what is it?	
		If not, would you like them to have one?	<input type="checkbox"/> Yes <input type="checkbox"/> No