

learning - how to live - together



Village
Montessori School

Admissions Questionnaire – Early Childhood

Today's Date _____

For Enrollment Beginning _____, _____

Applicant's Full Name _____

Gender _____

The name you call your child _____

Date of birth _____

Current age _____

Name of person completing this questionnaire _____

What is your greatest delight with your child? _____

What is your greatest challenge with your child? _____

What is your child's favorite way to socialize (e.g., large group, one-on-one, prefers grownups, prefers children, loud atmosphere, quiet atmosphere)? _____

Please describe your child's typical day (i.e., schedule, how does he/she help around the house, how does he/she spend their time, what activities do you do for fun, etc.) _____

How would you characterize your child's temperament within the family? Among other children? With adults? _____

How would you characterize your temperament(s) and how does this affect your parenting style with this particular child? _____

What parenting techniques do you find most helpful with your child? _____

Are you familiar with any of the following parenting techniques? Check all that apply.

- Attachment Parenting (Dr. Sears) Love and Logic (Jim Fay) Positive Discipline (Jane Nelsen)
 Educational Products (videos, flashcards, computer software, etc.) None of the Above
 Other _____

What aspects of Montessori's values or techniques attracted you to this type of education? _____

Are there any specific reasons why you believe Montessori is the right choice for this child? _____

What hopes/expectations do you have for your child's role in his family? school? community? _____

Knowing that each level(Toddler, Primary, or Elementary) is based on your child completing a full cycle of development, how long do you anticipate having your child attend VMS? _____

Does your child toilet independently? yes no If not, please indicate where your child is in this process.

Does your child have:

- | | | |
|--|---|--|
| <input type="checkbox"/> difficulty with large motor coordination? | <input type="checkbox"/> separation difficulties? | <input type="checkbox"/> behavior management issues? |
| <input type="checkbox"/> difficulty with fine motor coordination? | <input type="checkbox"/> vision difficulties? | <input type="checkbox"/> speech/language difficulties? |
| <input type="checkbox"/> difficulty making eye contact? | <input type="checkbox"/> a medical diagnosis? | <input type="checkbox"/> a psychological diagnosis? |
| <input type="checkbox"/> a hearing impairment? | <input type="checkbox"/> anger management issues? | <input type="checkbox"/> severe allergies? |
| <input type="checkbox"/> anxiety management issues? | | |

If yes, please describe what interventions you've found that help. _____

Has your child ever been recommended, tested, or received treatment for any medical, psychological, educational, or behavioral condition? yes no If yes, please describe (use additional sheets as necessary). _____

Please enclose all previous assessments, medical reports and/or doctors' recommendations, documentation, IEPs so we may better understand the individual needs of your child. Failure to disclose pertinent information may result in your child's dismissal from the program.

Does your child have any allergies, food or otherwise, that we need to be aware? _____

If the answer was yes, please explain how the symptoms manifest and what steps need to be taken if symptoms appear. _____
