



Morning Garden Preschool Application Form

Thank you for your interest in Mulberry Waldorf School!

Please complete this Application Form to the best of your ability and with full disclosure. Having an understanding of a child’s background, both personal and educational, will allow us to assess their needs more accurately. It is also important for our Faculty to have a full picture of the student to determine whether we can meet their needs while continuing to meet the needs of the children currently enrolled in the class. The information contained in this document will remain strictly confidential.

Please send this completed form to the [Administrative Head](#) in advance of your interview.

Child’s Name: _____

Pronoun: _____ Birth Date: _____
(MM/DD/YYYY)

Parent(s)’ Names: _____

Other members of the household: _____

Primary language: _____ Other languages: _____

Address: _____ City: _____

Phone: _____ Email: _____

- CORE PROGRAMS:**
- 2 morning (Thursday/Friday) morning
 - 3 morning (Monday/Tuesday/Wednesday) morning
 - 5 morning

CARE PROGRAMS	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
Optional afternoons must match morning programming and are from 12:00-3:30pm 2 afternoons, 3 afternoons or 5 afternoons					

***Due to licensing requirements, Extended Care is NOT available for Morning Garden.**

At what age did your child:

Get baby teeth: _____ Sleep all night: _____ Sit: _____

Crawl: _____ Stand: _____ Walk: _____

Use words: _____ Use sentences: _____ Become weaned: _____

Become toilet-trained: _____

*Please note that independent toileting by the first day of school is a requirement.

Please indicate if your child has been assessed in any of the following. Please attach a copy.

- | | |
|---|---|
| <input type="checkbox"/> Psychoeducational Assessment | <input type="checkbox"/> Occupational Therapy |
| <input type="checkbox"/> Speech & Language Assessment | <input type="checkbox"/> Pathways |
| <input type="checkbox"/> Hearing | <input type="checkbox"/> Sensory integration |
| <input type="checkbox"/> Eyesight | <input type="checkbox"/> Other Community Organization |
-

Have there been any exceptionalities (delays, challenges, or precociousness) associated with your child's development? Please explain.

Please record any concerns, observations, or pertinent information regarding (feel free to use back of page if necessary):

- | | | |
|---|--|--|
| <input type="checkbox"/> Hearing | <input type="checkbox"/> Fine motor | <input type="checkbox"/> Balance (coming to stillness) |
| <input type="checkbox"/> Speech | <input type="checkbox"/> Gross motor | <input type="checkbox"/> Persistent Fears |
| <input type="checkbox"/> Eyesight | <input type="checkbox"/> Co-ordination (falling) | <input type="checkbox"/> Sensitivity to touch/textures |
| <input type="checkbox"/> Sense of taste and smell | <input type="checkbox"/> Uprightness (trouble sitting, etc.) | <input type="checkbox"/> Other |
-



Please indicate and explain any follow up with your family physician regarding these or other concerns.

Has your child experienced any physical or emotional trauma (including death of a loved one), serious accident, or operations early in his/her life? If yes, please explain with dates.

Does your child have any medical dietary restrictions or allergies (celiac, anaphylaxis)? If so, please detail. Is your child on any medication? If so, what medications and for what condition?

How many hours does your child sleep without interruption each night? When is bedtime?

How many hours does your child sleep without interruption each night? When is bedtime?

What group experiences/programs has your child attended? What was their experience? How were their interactions with other children?

If your child has been in the care of another adult, how was the experience? Is your child able to ask for help? Does your child allow emotional and physical comforting from others?

Are there any challenges that you and your child are currently dealing with?

Does your child have extreme reactions or “triggers” (e.g., transitions, mealtimes, getting dressed)?

How much time does your child spend with each parent? Other care providers?



What is your approach to discipline?

Approximately how many hours per week does your child use any of the following?

T.V. _____ Computer _____

Video Games _____ Movies _____

Smartphone/Tablet _____

Are any changes in your home environment anticipated in the next year?

How do you anticipate your child will be on the first day/ in the first week of school?

***Thank you for taking the time to thoroughly complete this form.
All the information in this document will be treated as strictly confidential.
Please let us know if you have any questions about this form.***