This is how I draw myself





|  |
| --- |
| Things I like: |
| Things I do not like and what scares me: |
| Things I am good at: |
| What do I want to learn at school? |
| My friends are: |



This is how I write my name

|  |  |  |  |
| --- | --- | --- | --- |
| **Child’s full name:** | | | Date of birth: |
| Mother’s name: | | | |
| Father’s name: | | | |
| Other person/ legal representative: | | | |
| Class: | | | Date of entry |
| Brothers/sisters (names, date of birth) | | | |
| **Linguistic information** **Languages spoken at home** | | | |
| Mother: | | | |
| Father: | | | |
| Languages of other carers, e.g. Childminder/grandparents: | | | |
| Dominant language of the child | | | |
| **Previous educational experience please note the length of time attended** | | | |
| Playgroup: | Nursery: | Other: | |
| Comments | | | |
| Please give details of current out of school activities: | | | |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Me and the others Play** | | | | | | | | | |
| Please comment on games/ toys/activities that your child particularly enjoys | | | | | | | | | |
| Within the family: | | | | | | | | | |
| With friends: | | | | | | | | | |
| Playing alone: | | | | | | | | | |
| Comments | | | | | | | | | |
| **Me and the world language** | | | | | | | | | |
| When did your child begin to speak? | | | | | | | | | |
| Is his/her speech clear to you? | | | | | | | | | |
| To others? | | | | | | | | | |
| Comments | | | | | | | | | |
| **Me and my body** | | | | | | | | | |
| Has your child’s hearing ever been tested? | | | | | | | Yes | No | |
| By Whom? | | | | | | | | | |
| When? | | | | | | | | | |
| Outcome/comments: | | | | | | | | | |
| Does your child suffer from frequent colds/ blocked nose, etc? | | | | | | | Yes | No | |
| Comments: | | | | | | | | | |
| Has your child’s sight ever been tested? | | | | | | | Yes | No | |
| By Whom? | | | | | | | | | |
| When? | | | | | | | | | |
| Outcome/comments: | | | | | | | | | |
| Did your child crawl? | | | | | | | | | |
| At what age did your child start to walk? | | | | | | | | | |
| Is he/she independent dressing/undressing? | | | | | | | | | |
| Is he/she independent toileting by day/ by night? | | | | | | | | | |
| Is he/she independent eating? | | | | | | | | | |
| Comments: | | | | | | | | | |
| Please tick if your child has experience using: | | | | | | pencils/crayons | | |  |
| paintbrushes |  | threading beads |  | glue/paste |  | scissors | | |  |
| Comments: | | | | | | | | | |
| Is there any medical or other information which your child’s teacher needs to know? | | | | | | | | | |