AGBMS™
Alexander Graham Bell Montessori School

Preschool for All: PI Program Parent Interview Form
School Year 2026-2027 Ages 3-5
(Confidential)

Instructions: Interview form will be used to complete the PFA Eligibility form. Some areas have lightly shaded wording to indicate the types of responses that belong in that space.

<table>
<tr><td>Person Interviewed:</td><td>Date:</td><td colspan="3">Relationship to child:</td></tr>
<tr><td>Child's full name (First, Middle, Last):</td><td>(Circle)
Boy or Girl</td><td colspan="3">Place and Date of birth:</td></tr>
<tr><td colspan="5">The name I would like my child to go by is:</td></tr>
<tr><td colspan="5">How did you hear about this program?</td></tr>
<tr><td colspan="2">Mother's name (or significant female):</td><td colspan="3">Father (or significant male)</td></tr>
<tr><td colspan="2">Date of birth:</td><td colspan="3">Date of birth:</td></tr>
<tr><td colspan="2">Address:</td><td colspan="3">Address:</td></tr>
<tr><td colspan="2">City: State: Zip:</td><td colspan="3">City: State: Zip:</td></tr>
<tr><td colspan="2">Phone:</td><td colspan="3">Phone:</td></tr>
<tr><td colspan="2">Email:</td><td colspan="3">Email:</td></tr>
<tr><td colspan="2">Marital status:</td><td colspan="3">Marital status:</td></tr>
<tr><td colspan="2">Primary language spoken in home:</td><td colspan="3">Primary language spoken in home:</td></tr>
<tr><td colspan="2">Translator- Yes/No (If yes, describe):</td><td colspan="3">Translator- Yes/No (If yes, describe):</td></tr>
<tr><td colspan="2">Highest grade completed in school:</td><td colspan="3">Highest grade completed in school:</td></tr>
<tr><td colspan="2">Place of employment:
Address:
Phone number:</td><td colspan="3">Place of employment:
Address:
Phone number:</td></tr>
<tr><td colspan="2" rowspan="6">Does the child live with his/her
o Parent(s)?
o Foster parent(s) or legal guardian(s)?
o Other (specify):
Names (if other than parents):</td><td>List siblings:</td><td>Date of birth</td></tr>
<tr><td>Sibling</td><td>Date of birth</td></tr>
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<tr><td colspan="2">Notes:</td><td colspan="3">Are any of the child's siblings having academic difficulty or trouble in school? If yes, please explain:</td></tr>
</table>

Child's Medical History

Was there anything unusual about the pregnancy or delivery of this child or did he/she experience any serious health problems at birth? Yes/No
If yes, please explain:

Was there any drug or alcohol use during this pregnancy? Yes/No
If yes, please describe:

Length of this pregnancy:

Weight of child at birth:	Current weight:	Current height:

Did this child experience feeding difficulties as an infant? Yes/No
If yes, please explain:

Was this child on a respirator? Yes/No	If so, how long?

Is your child experiencing health issues? (Please indicate if the illness is chronic or terminal.)
If yes, please explain:

Does your child have a diagnosed disability?
If yes, please explain:

This child needs a referral to Child and Family Connections. Yes/No

Is this child taking any medication(s)? Yes/No
What medication(s) is this child taking?

Why is this child taking medication? Condition(s)

Please list any surgeries for this child.	Date	Hospital
Surgery	Date	Hospital
Surgery	Date	Hospital
Surgery	Date	Hospital
Surgery	Date	Hospital
Surgery	Date	Hospital

- Please list the name(s) and contact information of the doctor(s) for this child. On the next page

Doctor	Clinic/Office	Phone number
Doctor	Clinic/Office	Phone number
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Do you notice, or has a doctor reported any of the following in your child? (Circle)

- Thumb sucking
- Nail biting
- Epilepsy
- Heart trouble
- Overtired
- Lack of Appetite
- Overweight
- Underweight
- Frequent headache
- Nightmares
- Asthma
- Allergies (explain):

- Frequent indigestion
- Frequent constipation
- Frequent diarrhea
- Vomiting
- Frequent Fevers
- Sinus trouble
- Nose bleeding
- Rashes
- Frequent ear infections
- Night terrors
- Communicable diseases (explain):

Illness	**Yes**	**No**	**Age**	**Hospitalization/Where**
Measles	Yes	No	Age	Hospitalization/Where
Chicken Pox	Yes	No	Age	Hospitalization/Where
Mumps	Yes	No	Age	Hospitalization/Where
Strep Throat	Yes	No	Age	Hospitalization/Where
Tonsillitis	Yes	No	Age	Hospitalization/Where
Seizures	Yes	No	Age	Hospitalization/Where
Meningitis	Yes	No	Age	Hospitalization/Where
Whooping cough (pertussis)	Yes	No	Age	Hospitalization/Where

Question	Yes	No	Test Date	Test Result	Where
Does your child have a hearing problem?	Yes	No	Test Date	Pass/Fail	Where
If yes, describe:					
Adaptive equipment (specify):					
Does your child have vision problems?	Yes	No	Test Date	Pass/Fail	Where
If yes, describe:					
Adaptive equipment (specify):					
Has your child been diagnosed with a developmental concern?	Yes	No	Test Date	Pass/Fail	Where
If yes, describe:					

Adaptive equipment (specify):			
List therapy services child has received.	Therapist	Agency/Clinic	Phone number
Type of therapy	Therapist	Agency/Clinic	Phone number
Type of therapy	Therapist	Agency/Clinic	Phone number
Type of therapy	Therapist	Agency/Clinic	Phone number
Type of therapy	Therapist	Agency/Clinic	Phone number

Social History

Please describe your child.			
Does your child attend a child care program or in-home care?	Yes	No	Where:
Notes:			
Does your child have opportunities to play with other children?	Yes	No	Where:
Notes:			
Has your family experienced alcohol or drug abuse? If yes, please explain:			
Have you, or your child ever been exposed to stress, trauma, or violence? If yes, please explain:			
Is your family currently receiving services from the Department of Children and Family Services to resolve an abuse or neglect experience?			
Do any of the primary caregivers of this child have a chronic or terminal illness, mental illness or a disability? If yes, please explain:			
Age of mother at birth of first child? _____ Age of father at birth of first child? _____			
Has your family recently immigrated? Yes/No If yes, please explain:			
Are any of the primary caregivers of this child on active duty in the military? Yes/No If yes, please explain:			
Are any of the primary caregivers of this child incarcerated? Yes/No If yes, please explain:			
Has there been a death in the immediate family? (parent, child, sibling) If yes, please explain:			
Do you have opportunities to socialize and interact with family and friends? Please explain:			
Is your family receiving services from another agency? Yes/No If yes, please explain:			
What are your child's most enjoyable activities?			
What do you enjoy doing as a family?			

What frightens your child?
What do you do to comfort your child?
When moving from one activity to another or transitioning, how does your child respond?
What is a typical day like for you and your family?
Do you believe your child's development is similar to that of his/her peers? Please explain:
Have you noticed any regression in your child's development? Yes/No If yes, please explain:
List significant people in your child's life (person/relationship):
Does everyone in your family get enough to eat? Yes/No Do you have a place in your local community to get fresh food such as fruits and vegetables? Yes/No If no, please explain:
What is your child's eating/snacking schedule?
What is your child's sleeping/napping schedule?
Does your child have behaviors that concern you? If yes, please explain:
Describe any special information or instructions you would like program staff to be aware of:

Current pregnancy?	Yes	No	Estimated date of delivery:	Date of last exam:

Are you experiencing any difficulties with this pregnancy? Yes/No If yes, please explain:
Do you have any specific concerns about this pregnancy? Yes/No If yes, please explain:
Please list physicians addressing this pregnancy.

Doctor	Clinic/Office	Phone number
Doctor	Clinic/Office	Phone number
Doctor	Clinic/Office	Phone number
Doctor	Clinic/Office	Phone number

Household Information

Please report the number of times the family has moved in the past year:

What is your family's current living situation:

- o My family lacks a fixed, regular, and adequate nighttime residence.
  - ▪ My family shares housing of other persons due to loss of housing, economic hardship, or a similar reason.
  - ▪ My family lives in a motel, hotel, camping grounds due to lack of alternative adequate accommodations.
  - ▪ My family lives in emergency or transitional housing.
  - ▪ My family's nighttime residence is a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings.
  - ▪ My family lives in a car, park, public space, abandoned building, substandard housing, bus or train station, or similar setting.
- o Child is awaiting foster care placement.
- o I am an unaccompanied youth. I am not in the physical custody of a parent or guardian. (This includes runaways living in runaway shelters, abandoned buildings, cars, on the streets, or in other inadequate housing; children and youth denied housing by their families; and school-age unwed mothers living in homes for unwed mothers because they have no other housing available.)

As a parent, do you feel that reading and comprehension is easy or difficult for you? (Circle)

EASY DIFFICULT

Household structure:	Notes:
o Both parents at home o Single parent at home o Adult other than parent (guardian, grandparent) also in the home o Shared custody (part time with mom/part time with dad) o Teen parent lives with his/her parents Other situation (specify):	

Employment Status (Check appropriate box for each parent)	Mother	Father
Unemployed, not seeking employment (includes full-time homemaker)	Mother	Father
Unemployed, seeking employment	Mother	Father
Employed less than 20 hours per week	Mother	Father
Employed 20 hours or more per week	Mother	Father
Educational Status		
Current Student	Mother	Father
If yes, please explain:		

Financial Information

Please report the household annual income:	Report the number of people living in the household:

Public Programs: • Women, Infants, and Children (WIC) • Medicaid Card (must be in parent name) • Supplemental Nutrition Assistance Program (SNAP) • Temporary Assistance for Needy Families (TANF) • Child Care Assistance Program (CCAP)	Proof of Income (required only if no proof of public benefits above): • Paystubs • SSI • Other form of income verification- Describe:

Insurance Information	Yes	No
My family is enrolled in PRIVATE medical insurance from parent's work.	Yes	No
My family is enrolled in KidCare.	Yes	No
My family is enrolled in Medicaid.	Yes	No
My family has NO medical insurance.	Yes	No
My family has other insurance arrangements. Please specify:	Yes	No
My family is covered in the event of another pregnancy.	Yes	No
What are your dreams or goals for your child's future?		
Please provide any other information that will help us serve you and your family better.		

The information provided is true and accurate to the best of my (our) knowledge.

_____ _____

Parent/Guardian Signature Date

_____ _____

Parent/Guardian Signature Date

_____ _____

Staff Signature Date