Notes on filling out this form:
Please fill in or mark with a cross ☒

Answering all or just individual questions is voluntary!

Child's family name	Child's first name	Born on	Nationality	Number of other siblings

Native language (Mother)	Native language(Father)	Number of adults in the household	Has been attending a crèche/ daycare/kindergarten for ☐ years

Name and address of parent or legal guardian

Family name .... *First name*..................... *Place of residence/postcode*...

Street, house number.................... .... *Phone*...

Pregnancy and birth

Birth weight: I__I__I__I__I *grs.* Completed pregnancy weeks: I__I__I *PWs* ☐ Multiple birth

Development

Has any delayed development <u>ever</u> been determined in your child?	☐Yes	☐No
Unassisted walking by 18 months	☐Yes	☐No
First words (such as *mum*, *dad*, *car*) by 18 months	☐Yes	☐No
Speech disorder during development	☐Yes	☐No
Child grows up multilingual	☐Yes	☐No

Does your child have or has your child had one of the following illnesses or health impairments?

Visual impairment ☐ Yes ☐No Strabismus treatment ☐Yes ☐No Glasses ☐Yes ☐No

Does your child suffer from severe hearing impairment? ☐Yes ☐ No

If *Yes*, please answer the following questions:

☐ Severe congenital hearing impairment ☐ left ear ☐ right ear

☐ Acquired chronic hearing impairment ☐ left ear ☐ right ear

☐ Wears hearing aid since left ear ....*Month/year* right ear ....*Month/year*

☐ Wears cochlear implant since left ear ....*Month/year* right ear ....*Month/year*

Rare congenital metabolic or hormone disorders: ☐No ☐ Yes *(which?)* ....

Other chronic illnesses: ☐No ☐ Yes *(which?)* ....

Severe handicap: ☐No ☐ Yes *(which?)* ....

Must take the following medication regularly: ☐No ☐ Yes *(which?)* ....

Are you aware of illnesses your child may have that require specific procedures in emergency situations (e.g., allergies, epilepsy, etc.)? ☐ No ☐ Yes

If Yes, which? ....

Has your child ever had any of the following assistance measures or treatments?

Participation in German prep classes	☐ No	☐ Yes		
Speech therapy (logopedics)	☐ No	☐ Completed	☐ Ongoing	☐ Planned
Remedial education/ orthopaedagogy/ergotherapy	☐ No	☐ Completed	☐ Ongoing	☐ Planned
Physiotherapy	☐ No	☐ Completed	☐ Ongoing	☐ Planned
Psychological treatment	☐ No	☐ Completed	☐ Ongoing	☐ Planned

Family doctor/pediatrician: ....

....
Place, Date

....
Parent's or legal guardian's signature