

STELLENBOSCH WALDORF SCHOOL

Playgroup / Kindergarten & Primary School

CONFIDENTIAL INTERVIEW FORM

PLEASE ANSWER ALL QUESTIONS

Surname of child _____ Male/Female _____

Full Names _____ Preferred name _____

Date of Birth _____ Home Language _____ Religion _____

Ethnicity _____ Class applying for _____ as from _____

Marital Status of Parents: single/married/divorced/separated/remarried.

Is the child from this marriage/previous/adopted/other? _____

With whom does the child live? _____

Siblings	Age	School	Class	Teacher
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

FATHER

Surname _____ First Names _____

Residential Address _____

_____ Code _____

Postal Address _____

_____ Code _____

ID No. _____ Tel. (h) _____ Tel. (cell) _____

Details of profession _____

Employed by/own business _____ Tel No. _____

e-mail Address _____

MOTHER

Surname _____ First Names _____

Residential Address _____

_____ Code _____

Postal Address _____

e-mail address _____

ID No. _____ Tel. (h) _____ Tel. (cell) _____

Details of profession _____

Employed by/own business _____ Tel. _____

NAME OF PERSON RESPONSIBLE FOR FEES _____

SCHOOL HISTORY

Has the child been at a crèche /nursery school/day mother home? _____

_____ At what age _____ for how long _____

Present school _____ Tel. (compulsory to complete) _____

Address _____

Date and standard of entry _____ Teacher _____

Previous school attended:

School	Year	Standard
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Reasons for change of school(s):

Has the child been asked to leave a previous school Yes/No

If yes, state reason _____

Has the child failed any class? Yes/No

Describe the child's specific problems at the above school:

DOMESTIC SITUATION

a. In what environment did the child grow up? _____

b. Please describe your home atmosphere? _____

c. Do parents supervise homework? Yes/No

d. Does child have own bedroom? Yes/No If so with whom does child share with? _____

e. Sleep: Normal/heavy/restless/sleepwalking/nightmares. Wakes: immediately/ slowly

f. Mood of awakening _____

g. Any other comments _____

h. Has child been separated from parents for any reason? Yes/No For how long?

i. Change of country? _____ Which _____ Age _____ How long _____

j. Child's regular home tasks _____

- k. Special abilities, hobbies, interests etc. _____
- l. Does child watch TV regularly? Yes/No How many hours? _____
- Which programmes/music _____ Walkman? Yes/No

PRE-NATAL AND BIRTH HISTORY

- a. Pregnancy: Was it planned and expected pregnancy? Yes/No
- Air Flights during pregnancy? Yes/No Which months _____
- b. Health during pregnancy? Illness/infections/prolonged morning sickness
- Describe _____
- c. Birth: Full term/premature/slow/quick Birth weight _____
- Labour: induced/epidural/caesarean Why? _____
- Type of birth: normal/breech/forceps _____
- Complications? Describe _____
- At birth baby: cried immediately/delayed crying/difficulty in breathing/jaundice/blood transfusion/incubation
- Any Other comments _____
- d. Feeding: how long? Breast _____ Bottle _____
- Solids: when _____ Meat? When _____ Egg: when _____
- e. Please describe as a baby: happy/content/difficult/colicky _____
- f. General feeling towards baby at birth? _____
- Postnatal depression or other problems? Describe _____
- g. Vaccinations: Please list which at what age: _____
- h. Air flights after birth – what age, how often and destination _____
- _____ Any discomfort? e.g. crying _____

DEVELOPMENT

- a. When did child first: Sit _____ Crawl _____
- b. Did you use a: table carrier: Yes/No. How often _____
- Walking ring: Yes/No. How often _____
- Jolly Jumper Yes/No. How often _____
- c. Would describe child as clumsy? Yes/ No When _____
- d. Would you describe your child as hyperactive? Yes/No/Sometimes
- e. Were teeth late to appear? Yes/No. When _____

DEVELOPMENT (cont...)

- f. Age of: bladder control _____ bowel control _____
- g. Ages of the first words _____ Full sentences _____
- h. Has child had ear trouble? _____ Hearing loss _____
Difficulty in clarity/lisp/stutter/stammer/difficulty with any sound? Describe _____

- i. Has the child had any eye problem? Specify _____

HEALTH

- a. Has child been to specialist/psychologist/psychiatrist/other? _____
At what age? _____ Why _____
- b. Treatment/ medication _____
- c. Is the child still under medication? _____
- d. Operations? _____
- e. Any injuries or accidents involving head /eye/spine? _____
- f. Specify serious falls. _____
- g. Any other traumatic experiences? _____
- h. Childhood and other diseases: mumps/measles/meningitis/encephalitis/aids/hepatitis etc. _____
Age? _____ Medication _____
- i. Chronic illness? Frequent colds/asthma/allergies/bronchitis etc. _____

- j. Has child had any convulsions/ seizures? Yes/No. Type _____
Was this controlled by medication? Yes/No. When was the first seizure? _____
- k. Does child become feverish quickly? Yes/No Reason _____
- l. Is child prone to headaches? Yes/ No How often _____
- m. What is the condition of teeth? _____
Tonsils? _____ Adenoids? _____
- n. Present eating habits: appetite- eager/faddy/disinterested/overeater
Does child ever have stomach ache? Yes/No
Does child chew food well? Yes/No
Digestive disorders? Please describe _____
Does child have strong food preferences: salty/sweet/sour _____

SENSORY SYSTEM

- a. Does child seem to lack normal awareness of being touched? Yes/No
- b. Does child seem overly sensitive to being touched/held or cuddled Yes/No
- c. Does child pay attention to what is being said to him/her? Yes/No
- d. Is child easily distracted by sound? Yes/No
- e. Does child talk excessively? Yes/No
- f. Can child follow through instructions? Yes/No
- g. Handedness; Hand – L/R; Foot – L/R; Eye – L/R; Ear – L/R

BEHAVIOUR

- a. Is there any tension related behavior, such as nail biting/tongue showing/excessive blinking/rubbing of the eye/tantrums etc? _____
- b. Is child excessively shy/aggressive/restless/moody? _____
- c. Does child have friends? Many/few? _____
- d. Does child tend to play with children of the same age? Yes/No?

HISTORY RELATING TO OTHER INTERVENTIONS

- a. Has child had an educational assessment? Yes/No If yes: Date _____
By whom _____ Why? _____
Recommendations _____
- b. Has child had remedial lessons with any other person(s) _____
For what class/standard _____ How long? _____
Why? _____
- c. Describe child's difficulties as you see them _____

- d. What do you feel lies behind them? _____
- e. What is the child's attitude towards them? _____

How did you hear about The Stellenbosch Waldorf School? _____

PARENTS SIGNATURE _____ **DATE** _____

INTERVIEWING TEACHER _____

Comments.....
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