

How would you describe your child? \_\_\_\_\_

Has your child had previous formal group experience? When? What kind? How long? \_\_\_\_\_

Does your child have friends (same age) with whom (s)he plays frequently? \_\_\_\_\_

How does your child respond to new situations? \_\_\_\_\_

What interests does your child have? \_\_\_\_\_

How does your child respond to frustration? \_\_\_\_\_

How do you feel our school can help your child's growth, development , and Jewish experience?

I have selected your program for my child because \_\_\_\_\_

Any further comments you would like to share with our professional staff to help us maximize your child's experience at Temple Sinai?

**PARENT'S SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_

**PAST OR PRESENT THERAPEUTIC SITUATIONS:**

	NAME OF THERAPIST	DATE
SPEECH	_____	_____
OCCUPATIONAL	_____	_____
PSYCHOLOGICAL	_____	_____
OTHER	_____	_____