Kindergarten Parent Questionnaire

Please answer the following questions as accurately and completely as possible.

Your Child's Full Name (first, middle, and last):		
My child prefers to be called:		
Date of Birth:	Your child's age at this time:	Child's Gender M F
Name of Parent Completing Survey		

My child resides with:

___ Mother and Father
___Mother only
___ Father only
___ Mother and Stepfather
___ Father and Stepmother
___ Alternating time between mother and father in two households
___ Grandparent/s
___ Guardian
___ Other- Please specify: _____

Please list child's siblings including their names, age, and school they are currently attending:

Sibling's Name	Age	Name of School if applicable

Preschool History

Has your child attended Pre-school?

___ Yes ____No

If you answered yes to the previous question, please name the preschool attended:

_____

How many years of preschool did your child attend?	How many days a week did your child attend preschool?
___ 1 year ___ 2 years ___ 3 years	___ 2 days ___3 days ___ 4-5 days

Has your child ever had an Individual Education Plan?
__ yes
__ no

If yes, please explain here.

Does your child have difficulty with speech (articulation) or language?
___ yes
___ no
If yes, please explain:

What language does your family speak at home?

Health History

Does your child have any allergies?
____ yes
____ no
If yes, please explain:

Does your child take any medications on a regular basis?
____ yes
____ no
If yes, please explain:

Does your child have any difficulties eating or sleeping?
___ yes
___ no
If yes, please explain:

I anticipate my child will need guidance/support in the following areas:

___ Reading
___ Writing
___ Math
___ Developing Friendships
___ Feelings/Emotions
___ Attention/Focus
___ Behavior
___ Separation from home/parent
___ Independence
___ Listening and following directions

Please add any additional comments or concerns to help us better understand your child's needs:

Please describe the learning environment and or practices that helped your child learn best, during past learning experiences?

Which hand is more dominant? Circle one: Right Left Both

How much time do you spend reading at home with your child?

___ Little or no time
___ A few times a week
___ Almost daily
___ Daily

Does your child show an interest in books?

___yes
___ no

Does your child have access to books at home?

___yes
___ no

Does your child have experience using paper, pencil, scissors, and crayons?

___ yes
___ no

Can your child write his/her 1st name? ___ yes ___no

How does your child spend his/her time daily, when not at school? (hobbies, special interest, television, video games etc...)

How does your child feel about starting kindergarten?

____ enthusiastic/excited

____ anxious/worried

How do you feel about your child starting kindergarten?

____ enthusiastic/excited

____ anxious/worried

Other (please specify): _____

Please share any organized activities, clubs, or hobbies that your child participates in outside of school (e.g. baseball, soccer, music lessons):

Please share any additional information that will assist our staff in supporting your child for the kindergarten school year.