NORTHVIEW PUBLIC SCHOOLS

Kindergarten Parent Input and Questionnaire

(to be filled in by the parent/guardian and turned in at screening appointment)

Child's Name: ____ Date: ________________

Address: ____

Street City/State Zip

Place of Birth: _________________________ Date of Birth: ________________

Phone: Home _________________________ Cell _______________________

Email: ____________________________________

What name does the child go by at home? ________________________________

Is any language other than English spoken in the home? Yes/No
If yes, which language? ________________________________

Family Data

	Mother	Father
Name		
Country or state of birth		
Educational status		
Occupation		
Marital status		
Step parent (check if appropriate)		
Guardian (check if appropriate)		
With whom does the child reside		

Other Children in Family

Name	Age	Birth date	Male/Female

Family Relationships

Is there anyone other than the immediate family living in the home? Yes/No
Who? ____

Do other relatives play a role in your child's life? Yes/No
Who? ____

What does your family enjoy doing together? ______________________________

How does your child interact with other children in the family?
____

Who disciplines in the home?______________________________________

Which type of discipline do you feel is most effective with your child?
____

Developmental History (**Please give specific details**)

Were there any illnesses or complications during pregnancy or delivery? Yes/No
If yes, please explain?____

At which age did your child first:
Crawl ______ Sit ______ Stand ______ Walk ______ Talk ______ Potty Train ______

Did you have concerns with your child in early development? Yes/No
If yes, please explain?____

Is there a family history of speech, learning, or mental health problems? Yes/No
If yes, please explain? ____

Medical Information (**Please give specific details**)

Does your child have earaches, ear infections or PE tubes? Yes/No

Does your child experience any difficulties with his/her vision? Yes/No

What time does your child generally go to bed? ____________

Does your child sleep well? Yes/No
If not, please explain:____

Does your child take a daily nap? If yes, about what time? ____________ Yes/No

Medications taken by your child: (please specify, or indicate "none")
Current: ______________________________________
Past: ______________________________________

Does your child have any allergies? Yes/No

Type: Foods ________________________________

Medication ____________________________

Insects ________________________________

Other ________________________________

Is your child subject to respiratory infections? Yes/No

____

Has your child had any serious illness or accidents?

____

Has your child ever been hospitalized? Yes/No

____

Does your child have any other health problems? Yes/No

____

COMMUNITY EXPERIENCES

Has your child had any preschool or daycare experience? Yes/No

If yes, where and what was the schedule ? ____

Did your preschool teacher recommend (circle one): Developmental Kindergarten Kindergarten

Do you agree? Yes/No

____

How has your child felt about his/her early school or daycare experiences (reactions, attitudes)

____

____

Does your child have opportunities to interact with same age peers? Yes/No

In what setting, how often and for what amount of time?

____

Please Circle Which Applies to Your Child the Majority of the Time:

Social|Emotional Development		
Does your child:		
o separate easily from you/caregiver	Yes	No
o help with chores around the house	Yes	No
o seem concerned when others are hurt	Yes	No
o dress himself/herself	Yes	No
o ask for help when needed	Yes	No
o independently use the bathroom	Yes	No
o follow directions	Yes	No
Motor Development		
Which hand does your child prefer to use?	Right	Left
Does your child:		
o copy shapes	Yes	No
o write his/her name	Yes	No
o use scissors correctly	Yes	No
o tie his/her shoes	Yes	No
o draw pictures that are recognizable	Yes	No
o demonstrate gross motor skills, e.g. run, ride bike, throw ball, etc.	Yes	No
Cognitive Development		
Can your child :		
o tell others his/her first and last name	Yes	No
o tell others his/her age	Yes	No
o tell others his/her address	Yes	No
o tell others his/her telephone number	Yes	No
o name at least five colors	Yes	No
o recognize numbers 1-10	Yes	No
o recognize most lower case letters	Yes	No
o recognize most uppercase letters	Yes	No
o share information about a story after you read to him/her	Yes	No
o recognize his/her name in print	Yes	No

Check All That Apply:

When with another child or in a same age group, does your child usually:

- o Play away from others or by himself/herself
- o Avoid hurting others
- o Play silently next to others
- o Actively play with others
- o Talk by himself/herself while playing
- o Watch other children play
- o Share and take turns willingly
- o Make eye contact while talking with others

- Engage in pretend play by himself/herself
- Engage in pretend play with others
- Create imaginary playmates or worlds
- Willingly and cooperatively participate in a small group activity or game

Additional Information:

Does your child have any special needs? (circle all that apply)

Speech Language Sight Hearing Physical Serious Illness

Other: ____

Does your child have an IEP/504 Plan? Yes/No

What are some of your child's:

Interests ______________________________ Abilities __________________________________

Fears ________________________________ Likes/Dislikes _____________________________

What do you consider to be areas of strength for your child?

____

What is challenging for your child?

____

Has your child had any unusual social/emotional experiences?

____

Are there any current family/home situations that may be impacting your child?
(housing, family separation, birth of siblings, new jobs, etc.)

____

Please add any other family information you feel would be helpful in understanding your child:

____
____
____
____
____

Form completed by: ____________________________ Relationship to Student: ____________________________

Date: ____________________ Staff Interviewer: _______________________________