NORTHVIEW PUBLIC SCHOOLS
Kindergarten Parent Input and Questionnaire
(To be completed by the parent/guardian and returned at your 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 the Family:

NAME	AGE	DOB	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
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 (check 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 Check Which Applies to Your Child the Majority of the Time:

Social/Emotional Development

Does your child:
Separate easily from you/caregiver Yes☐ No☐
Help with chores around the house: Yes☐ No☐
Seem concerned when others are hurt Yes☐ No☐
Dress himself/herself Yes☐ No☐
Ask for help when needed Yes☐ No☐
Independently use the bathroom Yes☐ No☐
Follow directions Yes☐ No☐

Motor Development

Which hand does your child prefer to use? Right☐ Left☐

Does your child:

Copy shapes Yes☐ No☐
Write his/her name Yes☐ No☐
Use scissors correctly Yes☐ No☐
Tie his/her shoes Yes☐ No☐
Draw pictures that are recognizable Yes☐ No☐
Demonstrate gross motor skills, e.g. run, ride bike, throw ball, etc. Yes☐ No☐

Cognitive Development

Can your child:
Tell others his/her first and last name Yes☐ No☐
Tell others his/her age Yes☐ No☐
Tell others his/her address Yes☐ No☐
Tell others his/her telephone number Yes☐ No☐
Name at least five colors Yes☐ No☐
Recognize numbers 1-10 Yes☐ No☐

Recognize most lower case letters Yes☐ No☐
Recognize most uppercase letters Yes ☐ No ☐
Share information about a story after you read to him/her Yes☐ No☐
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:

- ☐ Play away from others or by himself/herself
- ☐ Avoid hurting others
- ☐ Play silently next to others
- ☐ Actively play with others
- ☐ Talk by himself/herself while playing
- ☐ Watch other children play
- ☐ Share and take turns willingly
- ☐ Make eye contact while talking with others
- ☐ Engage in pretend play by himself/herself
- ☐ Engage in pretend play with others o Create imaginary playmates or worlds o Willingly and
- ☐ cooperatively participate in a small group activity or game

Additional Information:

- ☐ Does your child have any special needs? (check 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: _____