Kindergarten Questionnaire

Student's Name: _____
(First) (Middle) (Last)

Date of Birth: _____ Birthplace: _____

Mother's Name: _____ Resides with the student? Yes No

Father's Name: _____ Resides with the student? Yes No

Other Adults in the Home: _____

Siblings

(Please list the birth dates of brothers and sisters. List from oldest to youngest, including this child)

Name	Date of Birth	Lives with the student?	
		Yes	No
		Yes	No
		Yes	No
		Yes	No
		Yes	No
		Yes	No

Medical Information

Has the child ever been treated or had medication for social, emotional, or behavior concerns? _____

_____

_____

_____

Has the child ever had difficulty with speech and language, fine motor, or gross motor skills? (For example, he/she took a long time to talk in sentences, he/she is hard to understand, he/she took a long time to walk or run). If yes, please describe: _____

_____

_____

_____

Toileting habits (day and night): _____

Sleeping habits (bedtime and how many hours he sleeps): _____

Is your child under the care of any medical professionals in addition to the pediatrician (for example, eye doctor, psychologist, neurologist, etc.)? _____

_____

_____

Are there any other concerns regarding the health and behavior of your child which the school should know in order to help him/her adjust to the school program? _____

_____

_____

_____

My child

1. (Is – Is not) eager to start school
2. (Always - Sometimes - Never) takes a nap in the (morning - afternoon)
3. (Has – Has not) attended nursery/preschool? If yes, please indicate the school and duration

Age when your child attended	Name of the School/Program	How often did your child attend? (Daily, 3 days/week, ½ days, etc.)	How long did your child attend?

4. (Can - Cannot) dress himself (coat, boots, shoes, etc.)
5. Usually goes to bed (7 - 8 - 9 - later)
6. (Is - Is not) used to playing with other children
7. (Does - Does not) have playmates
8. (Does - Does not) seem to prefer to play alone
9. (Will – Will not) generally share with others
10. (Will – Will not) respond to correction by an adult
11. (Is - Is not) shy with other children
12. (Is - Is not) shy with adults
13. (Will – Will not) easily separate from parents
14. (Is - Is not) willing to try new things
15. (Does - Does not) have a problem with bladder control
16. Is (Right Handed - Left Handed - No dominance yet)

My child likes: _____

My child dislikes: _____

How would you describe your child? _____

_____

Does your child have a very close friend who is also entering kindergarten this year? If yes, please indicate the friend's name _____

Is there any other information you'd like to share with us about your child in order for the school to help him/her adjust to kindergarten? _____

_____

For Office Use Only

Reviewed by _____

Date _____