



- PARENTAL QUESTIONNAIRE -

Kindergarten Entry

Student Name:

School:

Birthdate:

The information collected through this questionnaire will provide valuable information to teachers and support staff as they plan programs that will address the various interests and needs of the children within the kindergarten classroom.

Kindergarten Questionnaire

Self-Help Skills:

- | | | |
|----------------------------------------------------------------|-----|----|
| 1. My child washes and dries own hands without help. | Yes | No |
| 2. My child undresses without help. | Yes | No |
| 3. My child dresses without help. | Yes | No |
| 4. My child buttons clothing. | Yes | No |
| 5. My child usually takes care of personal belongings. | Yes | No |
| 6. My child is toilet trained. | Yes | No |
| 7. My child can zip and unzip items of clothing independently. | Yes | No |
| 8. My child can put on and fasten velcro shoes. | Yes | No |

Comments: _____

Academic Readiness:

- | | | |
|-----------------------------------------------------------|-----|----|
| 1. My child counts to 5 _____, 10 _____, or beyond _____. | Yes | No |
| 2. My child understands the concept of number (1 to 5). | Yes | No |
| 3. My child points to and names pictures in books. | Yes | No |
| 4. My child understands stories read to him/her. | Yes | No |
| 5. My child tries to read books from memory. | Yes | No |
| 6. My child recognizes his/her name in print. | Yes | No |
| 7. My child can print his/her name. | Yes | No |
| 8. My child can recognize most basic colours. | Yes | No |

Comments: _____

Visual/Fine Motor:

- | 1. My child prefers to use... | Left Hand | Right Hand | Unsure | |
|----------------------------------------------------------------------|-----------|------------|--------|----|
| 2. My child uses pencils and or crayons. | | | Yes | No |
| 3. My child tries to stay within the lines when colouring a picture. | | | Yes | No |
| 4. My child uses scissors to cut paper. | | | Yes | No |

Comments: _____

Physical:

- | | | |
|----------------------------------------------------------------------|-----|----|
| 1. My child walks and runs well (rarely falls or bumps into things). | Yes | No |
| 2. My child usually goes up and down stairs without difficulty. | Yes | No |
| 3. My child appears to have good physical health and stamina. | Yes | No |

Comments: _____

Health Information:

The school should be aware of the following health information about my child:

1. (a) Life-Threatening Allergies:

1. (b) Allergies/asthma/other medical conditions:

2. Sleeping patterns:

3. Medications:

- | | | |
|----------------------------------------------------------------------|-----|----|
| 4. Were there any concerns regarding pregnancy, delivery or infancy? | Yes | No |
| 5. Were there any concerns regarding early development? | Yes | No |
| 6. My child has had a vision test. | Yes | No |
| 7. My child should wear glasses at school. | Yes | No |

Comments: _____

Social/Emotional/Self-Reliance:

1. My child is involved in: Home Day Care Child Care Setting Organized Community Activities

Length of Time: _____

2. In this setting, my child enjoys: _____

3. My child's favourite activities are: _____

4. When my child does not get his/her own way, he/she often will:

5. Words to describe my child's personality: (e.g., active, outgoing, quiet, easy-going, aggressive, nervous, excitable, happy, etc.)

6. When my child is asked to do a challenging task, he/she often will:

7. When my child is in a new situation, he/she often will:

8. Has your child experienced any significant changes in his/her family life? (e.g., birth of a baby, death of a family member, moving, separation/divorce, etc.)

9. My child usually plays well with at least one child.	Yes	No
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10. My child interacts easily with adults.	Yes	No
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11. My child uses toys safely and appropriately, most of the time.	Yes	No
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12. My child engages willingly in new activities.	Yes	No
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13. My child usually continues an activity without constant attention and encouragement.	Yes	No
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14. My child is unusually shy.	Yes	No
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Comments: _____

Speech/Language:

- 1. My child's first language is: _____
- 2. Other languages spoken in our home include: _____
- 3. My child can tell his/her first name and last name. Yes No
- 4. My child can name many objects. Yes No
- 5. My child follows two step directions. (e.g., touch your nose, then clap your hands). Yes No
- 6. Other people usually understand my child's speech. Yes No
- 7. My child speaks in sentences of four or more words. Yes No
- 8. My child can use some personal pronouns (e.g., he, she, her, him) appropriately. Yes No
- 9. My child can verbalize personal needs such as hungry, thirsty, sleepy. Yes No
- 10. My child can tell or retell a story. Yes No
- 11. My child has experienced several ear infections. Yes No
- 12. My child has had middle ear tubes inserted. Date: _____ Yes No
- 13. My child has experienced a hearing test. Results: _____ Yes No
- 14. My child has received, is receiving, or is on a waiting list for speech and language services from a community agency. Yes No
- 15. I have concerns about my child's speech and language. Yes No

Comments: _____

Special Services:

1. Are there any community agencies currently providing support to your child? Yes No
If yes, please list the agency and describe the services provided.
(e.g., CCAC, Renfrew Developmental Services, CHEO).

2. Does your child have any assessment reports which can be provided to the school? Yes No
If yes, please list /date the report(s).

Thank you for taking the time to complete this form. It will provide valuable information to school personnel who may be involved in planning your child's learning.

I give my consent for the School Board Services to review this information as necessary.

Parent/ Guardian Signature

Date