



## TRANSITIONAL KINDERGARTEN STUDENT INFORMATION SHEET 2016-2017

Dear Parents/Guardians,

Please complete the following questionnaire to help us become better acquainted with your child:

Date: \_\_\_\_\_ Home Phone Number: \_\_\_\_\_

1. Child's Name: \_\_\_\_\_ Gender \_\_\_\_ Date of Birth \_\_\_\_\_

2. Parent's Name(s) (Child lives with): \_\_\_\_\_

Circle relationship: M (mother) F (father) S/F (stepfather) S/M (stepmother) G (guardian)

3. Address: \_\_\_\_\_ Phone # \_\_\_\_\_

4. Parent's Name(s) (Child does not live with): \_\_\_\_\_

Circle Relationship: M (mother) F (father) S/F (stepfather) S/M (stepmother) G (guardian)

5. Address: \_\_\_\_\_ Phone # \_\_\_\_\_

**6. Parents' Work Information:**

Name \_\_\_\_\_

Relationship \_\_\_\_\_ Work Phone # \_\_\_\_\_

Employed by (name & address): \_\_\_\_\_

Name \_\_\_\_\_

Relationship \_\_\_\_\_ Work Phone # \_\_\_\_\_

Employed by (name & address): \_\_\_\_\_

**7. Do you speak another language other than English in your home?**

Yes \_\_\_\_ No \_\_\_\_ If 'yes', which language? \_\_\_\_\_

8. If you want your child to be known by a shortened variation or nickname rather than his/her "formal" name, please write the name here \_\_\_\_\_

9. Names and ages of siblings: \_\_\_\_\_

(OVER →)

**Pre-School Experience**

10. Has your child had pre-school experience? Yes \_\_\_\_\_ No \_\_\_\_\_

If Yes, how many hours per day? \_\_\_\_\_ At what age did s/he begin? \_\_\_\_\_

Which pre-school did your child attend? \_\_\_\_\_

Name of teacher \_\_\_\_\_ School Phone # \_\_\_\_\_

11. Has your child had childcare experience? Yes \_\_\_\_\_ No \_\_\_\_\_

12. What does your child like to do at home? \_\_\_\_\_

\_\_\_\_\_

at pre-school? \_\_\_\_\_

13. What is your child's order of birth in your family? \_\_\_\_\_

14. What pleases you most about your child's development? \_\_\_\_\_

15. What concerns you most about your child's development? \_\_\_\_\_

16. How does your child feel about coming to Transitional Kindergarten?

Apprehensive? \_\_\_\_\_ Not sure? \_\_\_\_\_ Excited? \_\_\_\_\_

Comment(s) \_\_\_\_\_

17. Dominant Side

Left \_\_\_\_\_ Right \_\_\_\_\_ Ambidextrous \_\_\_\_\_

18. What are your expectations for your child's Transitional Kindergarten experience? (List several, if you so desire.)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Form Completed by \_\_\_\_\_

Print Name

Relationship to child \_\_\_\_\_

Signature \_\_\_\_\_