

## KINDERGARTEN STUDENT INFORMATION SHEET 2017-2018

Dear Parent/Guardian,

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/Guardian Name(s) (Child lives with): \_\_\_\_\_

Relationship: Mother/s Father/s Stepfather Stepmother Guardian Custodian

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

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

5. Relationship: Mother/s Father/s Stepfather Stepmother Guardian Custodian

Address: \_\_\_\_\_ Phone # \_\_\_\_\_

6. Parent/Guardian Work Information:

Name \_\_\_\_\_

7. Relationship \_\_\_\_\_ Work Phone # \_\_\_\_\_

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

8. Name \_\_\_\_\_

9. Relationship \_\_\_\_\_ Work Phone # \_\_\_\_\_

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

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

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

11. 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 \_\_\_\_\_

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

13. What does your child's bedtime routine look like?

14. What responsibilities does your child have at home (ie. dressing oneself, picking up toys, etc.)?

15. What types of consequences and incentives do you use to redirect your child's behavior?

16. Does your child having any diagnosed disability which could affect his/her learning (examples: ADD, autism or other spectrum disorder, physical disability, sensory processing disorder)?

17. Is there another child your child learns best with and/or should be separated from?

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

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

Name of Pre-School \_\_\_\_\_

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

19. If no pre-school experience, has your child had childcare experience? Yes \_\_\_\_\_ No \_\_\_\_\_

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

at pre-school or with childcare? \_\_\_\_\_

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

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

\_\_\_\_\_

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

\_\_\_\_\_

24. How does your child feel about coming to Kindergarten?

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

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

\_\_\_\_\_

25. Dominant Side      Left                  Right                  Ambidextrous

26. What are your expectations for your child's Kindergarten experience?