Kindergarten Questionnaire

Child's Name:_____ Gender M F

Child's Birthdate: (month) _____ (date) _____ (year) _____

How would you like your child to write his/her first name? (ex: Mike for Michael) _____

Parent(s)/Guardian(s) Name(s):_____

Address:_____

City: _____ Zip Code: _____

Home Phone Number:_____

Parent(s)/Guardian(s) Cell Phone Number(s):_____

Language(s) spoken in home:_____

Language(s) your child speaks:_____

Has your child attended preschool, if yes where at and since when? _____

_____

List any health concerns or allergies your child has:_____

_____

Please circle your response to each question about your child

Which hand is your child's dominant writing hand?	left	right
Can your child print his/her first name independently, first letter capital and rest lowercase? (ex. )	yes	no
Can your child use scissors to cut paper?	yes	no
Students will be using an Ipad with our curriculum: Does your child have experience using an Ipad/tablet	yes	no
Does your child have trouble expressing him/herself verbally?	yes	no
Does your child have trouble seeing things that are far away?	yes	no
Do you read to your child daily?	yes	no
Can your child remain attentive for 10 minutes during learning activities?	yes	no

 Almost done....please finish backside

Please help the teacher get to know your child

Please list all adults living in your home:

Name	Relationship

Please list all the children living in your home:

Name	Age	Gender

What are your child's academic and social strengths?

How does your child feel about starting full-day kindergarten?

How does your child get along with other children?

Does your child have any problems with learning?

Is there anything else you would like the teacher to know about your child? (i.e. moving, new sibling, divorce, or death)...

 You are done...thank you!