Kindergarten Enrollment Questionnaire

As Kindergarten teachers, we believe the first year of school lays an important foundation for a student's future. In order for us to best meet your child's social, physical & academic needs, please complete the following information. ** THIS INFORMATION IS CONFIDENTIAL and is used strictly for the purpose of becoming better acquainted with you and your kindergartener. ** Please note: Placement is not complete without this form. Thank you!

MISSOULA COUNTY PUBLIC SCHOOLS

Forward Thinking, High Achieving.

Today's Date: _____

Child's Full Name: _____ Gender: M / F

*Name to be used in school: _____ Date of Birth: _____

Name of Person Completing Questionnaire: _____

Relation to Child: _____

FAMILY BACKGROUND

HOUSEHOLD #1:

Child Lives with the Following Adults (Please include names and relations):

_____

_____

Other Children in the Household:

NAME/RELATION	GENDER	AGE	GRADE
_____	M / F	_____	_____
_____	M / F	_____	_____
_____	M / F	_____	_____

HOUSEHOLD #2 (if applicable):

Child Lives with the Following Adults (Please include names and relations):

_____

_____

Other Children in the Household:

NAME/RELATION	GENDER	AGE	GRADE
_____	M / F	_____	_____
_____	M / F	_____	_____
_____	M / F	_____	_____

Please list any special living situations that may help us understand your child's daily schedule:

_____

GENERAL HEALTH INFORMATION

Please list any medical conditions (diabetes, seizures, etc.) your child has including food and/or environmental allergies: _____

Please list any medication(s) your child takes and indicate whether they need to be administered at school:

_____

Are you aware of any speech, vision, or hearing impairments? If so, please list:

_____

Has your child ever been evaluated by a professional? YES ☐ NO ☐

(Speech Therapist, OT, PT, Behavior Specialist, Psychologist, etc.) **If yes:**

Reason for evaluation: _____

Name of Specialist: _____

Location of services: _____ Date of services: _____

Is your child receiving any services now? _____

Does your child currently have an IEP? _____

SOCIAL EXPERIENCES

1. Has your child attended preschool? _____ For how long? _____

Name of preschool(s) attended: _____

2. Does your child play quietly or actively? _____

3. Would you say your child is a leader or a follower? _____

4. What activities does your child enjoy outdoors? _____

5. What activities does your child enjoy indoors? _____

6. Please list any organized sports, clubs or other activities in which your child has participated: _____

_____

Development

1. Language(s) spoken at home: _____
2. Does you child spend time looking at books? YES ☐ NO ☐
3. Do you read to your child? YES ☐ NO ☐ How often? _____
4. Is your child able to remember songs and rhymes? YES ☐ NO ☐
5. Is your child right or left handed? LEFT ☐ RIGHT ☐ NO DOMINANCE YET ☐

Development continued →

DEVELOPMENT CONTINUED

6. Has your child had experiences with scissors? YES ☐ NO ☐

7. Please circle the items your child can do independently:

button ☐ tie shoes ☐ snap ☐

Zip ☐ lace shoes ☐ fasten ☐

8. Does your child follow dressing, undressing, toileting and washing routines independently? YES ☐ NO ☐

If no, please indicate which routines are still developing: _____

_____

9. Is your child able to print his/her first name? YES ☐ NO ☐ WITH HELP ☐

10. How many letters in the alphabet can your child identify? _____

11. Please circle the shapes your child can identify: circle ☐ triangle ☐ rectangle ☐ square ☐ oval ☐

12. Please circle the colors your child can identify:

Red ☐ orange ☐ yellow ☐ green ☐ blue ☐ purple ☐ black ☐ white ☐ brown ☐ pink ☐

13. Does your child have a known vision-related color deficiency? YES ☐ NO ☐

SCHOOL ADJUSTMENT

1. My child's energy level (excluding TV time) can be described as:

☐ A) Always on the go

☐ B) Sometimes able to sit for 10 minute stretches

☐ C) Maintains interest in one activity for 20 minutes or more

2. Does your child listen without interrupting while someone else talks? YES ☐ NO ☐

3. What daily or weekly responsibilities does your child have around home? _____

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_____

4. What is your child's regular bedtime? _____

5. How many hours per night does your child typically sleep? _____

6. How many hours per day does your child:

A) Watch television: _____

B) Use a computer/I Pad/Smart Phone: _____

C) Play video games: _____

7. What three words best describe your child?

1. _____ 2. _____ 3. _____

8. Please list two things that interest your child:

1. _____

2. _____

9. Please list two things that cause your child to be easily upset:

1. _____

2. _____

10. Does your child have any fears we should know about? _____

_____

11. What are some of your child's strengths? _____

_____

12. What are some skills/areas in which your child would benefit from extra practice?

_____

_____

13. What do you hope your child will gain through the kindergarten experience?

_____

_____

14. What else would you like your child's teacher to know about him/her?

_____

_____

15. Is there anything you would like to share with us that may affect your child here at school?

_____

_____

Please rate your child's tendencies in the following areas:

	Usually (4/5 times)	**Sometimes** (3/5 times)	**Rarely** (1/5 times)	**Never** (0/5 times)	**Need Support?**
Follows rules & routines					
Can move from one activity to another easily					
Can engage in a learning activity independently for 10 minutes					
Plays well with one or more children					
Able to share & take turns					
Uses words to resolve conflict					
Seeks adult help when needed to solve conflicts					
Toilets independently					
Can state his or her full name					
Participates in group activities					
Easily separates from parents					
Tantrums easily when things do not go his/ her way					
Sensitive/cries easily					

Thank you for your time. We look forward to getting to know your child and working together with you to create a successful kindergarten year!