**For Office Use Only** **Child's Name:**_____**Screening Date:**_____**Arrival Time:**_____

# Ayer Shirley Regional School District Parent Questionnaire for Preschool Screening

Dear Parents:

Please take a few moments to introduce your child to us through this questionnaire.

This form has four parts that ask for information about your child:

| | |
|---|---|
| Part 1: | Personal background information about your child. |
| Part 2: | Health information about your child. |
| Part 3: | Self-Help Development about your child's ability to care for him/herself. |
| Part 4: | Social Development about how your child behaves with other people. |

Please read through the form and respond to all items as carefully as you can. You are an important source of information about your child. The information and answers that you provide enable us to better understand the whole child. Information shared on this questionnaire will remain confidential and will only be shared with your child's classroom teacher and specialist teachers. We greatly appreciate your time in completing this form and look forward to working with you and your child.

Child's Name (First, Last):_____

Name child will be using in school:_____

Date of Birth:____/____/____ Gender:_____Male ____Female

***Parent***

Mr/Mrs/Ms/Other:_____

Name (First/Last)_____

Address:_____

City:_____State:_____Zip:_____

Home Phone:_____

Cell Phone:_____

Email for school contact:_____

Person completing this survey:_____Mother_____Father_____Guardian____Caregiver_____Other (specify) _____

## Part 1: Personal Information

**Living Situation**

1. Who does your child live with? (Check all that apply)

___Mother ___Father ___Stepmother ___Stepfather ___Mother's Partner ___Father's Partner

___Grandmother ___Grandfather ____Other relative (specify)_____

___Foster family: Case worker's name and phone #:_____

___Other (specify)_____

2. Is the child adopted?____Yes ___No
3. If your child is adopted at what age did he/she join the family?_____

**Siblings**

4. Does your child have brothers or sisters?____Yes (Please list below)____No

| Name of brother/sister | Age | Name of School Attending | Does this child live at home with your kindergartner? |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

5. My child's birth order in the family is____out of___children.

**School situation**

6. What are your concerns about your child's schooling?_____
_____
_____
7. Has your child attended a preschool/ daycare?____Yes____No If yes, for how long? (years/months)_____
8. How many hours per week has your child most recently attended preschool or daycare?_____
9. What is the name and location of your child's preschool/daycare?_____
Preschool or Daycare contact person's name:_____
10. May we have permission to contact the previous teacher/daycare provider?____Yes___No *If yes, please sign below.*
Signature:_____Date:_____

**Home Situation**

11. When was the last time you moved?_____
12. How often have you moved in the last 5 years?_____
13. Have any of the following occurred?
Parents separated or divorced_____Yes ___No When?_____
A death or major loss ___Yes ___No Who/When_____
Other major events that may have upset your child?_____
_____Date:_____
14. Has your child reacted to any of the above situations with behaviors that concern you? _____
_____
_____
15. Are there any family beliefs, traditions (religious or otherwise) that you would like the school to be aware of? _____
_____

## Part 2: Developmental History

**Information**

16. Was the child a full term baby? ___Yes ___No
17. Were there any complications with the pregnancy or at birth? ___Yes ___No
If YES explain:_____

**Medical/Health Information**

18. Did your child receive Early Intervention Services? ___Yes ___No
If YES, with whom?_____

19. Has your child seen an optometrist or ophthalmologist? ___Yes ___No
20. Does your child wear glasses? ___Yes ___No
21. Do you suspect your child has a vision problem? ___Yes ___No
    Comments:_____
22. Do you suspect your child has a hearing problem? ___Yes ___No
    Comments:_____
23. Is your child under the care of an audiologist or ear, nose and throat (ENT) specialist? ___Yes ___No
24. Has your child had frequent ear infections? ___Yes ___No
25. Has your child had ear tubes inserted? ___Yes ___No
    If YES, at what age(s)?_____
26. Does your child speak loudly? ___Yes ___No
27. Does your child have a significant medical history due to an accident, illness or medical condition? ___Yes ___No
    If YES, please describe:_____
28. Has your child ever been hospitalized? ___Yes ___No
    If YES, please explain:_____
29. Does your child take prescription medications on a routine, daily basis? ___Yes ___No
    If YES, please list:_____
30. Does your child have any allergies? ___Yes ___No
    If YES, please list:_____
31. Does your child have an EPI PEN? ___Yes ___No
32. Does your child use an asthma inhaler? ___Yes ___No
33. Has your child ever had a special assessment for : (Please circle, if applicable)
    **Cognitive or Developmental exam** **Psychological exam** **Neurological exam**
    If your child has had one of the above exams, please describe the reason(s):_____
    _____
    Name and location of person(s) who administered the exam:_____
    _____
34. Has your child ever experienced a major psychological trauma? ___Yes ___No
    If YES, please describe:_____
35. May we have permission to contact your child's medical provider, as needed?___Yes ___No *If yes, please sign below*
    Medical provider's name:_____Phone #:_____
    Signature:_____Date:_____

**Speech/Language Information**

36. My child has had a **speech and language evaluation**. ___Yes ___No
    If YES, did he/she receive therapy?___Yes ___No For how long?_____
37. My child <u>currently</u> receives **speech and language therapy.** ___Yes ___No
    Therapist's name/agency:_____
38. My child is generally understood by people outside the family. ___Yes ___No
39. I find myself restating what my child has said to others. ___Yes ___No

**Motor Information**

40. My child can **<u>independently:</u>** (check all that apply)
    ____Throw or catch a ball ____Go up stairs with alternating feet ____Go down stairs with alternative feet
    ____Hop on one foot ____Hope of two feet ____Balance on one foot for 3-5 seconds
41. My child has had a **physical therapy evaluation**. ___Yes ___No
    If YES, did he/she receive therapy?___Yes ___No For how long?_____
42. My child <u>currently</u> receives **physical therapy.** ___Yes ___No
    Therapist's name/agency:_____

**Sensory Information**

43. My child is fearful of loud noises. ___Yes ___No
44. My child does not like crowds. ___Yes ___No
45. My child is a picky eater (does not like certain food textures, colors, etc.) ___Yes ___No

46. My child becomes overwhelmed in new situations. ___Yes ___No
47. Certain clothing (tags, different materials, etc.) bother my child. ___Yes ___No

**Fine Motor Information**

48. My child can hold a crayon and draw/color with it. ___Yes ___No
49. My child can string beads. ___Yes ___No
50. My child can snip with scissors. ___Yes ___No
51. My child can copy a horizontal line, a vertical line and a circular shape. ___Yes ___No
52. My child has had an **occupational therapy and/or sensory evaluation.** ___Yes ___No
    If YES, did he/she receive therapy?___Yes ___No For how long?_____
53. My child currently receives **occupational therapy.** ___Yes ___No
    Therapist's name/agency:_____

**Attention Information**

54. My child gives eye contact to the person speaking. ___Yes ___No
55. My child sticks to one activity for at least 5 minutes at a time (not including computer or TV) ___Yes ___No
56. My child perseverates or excessively over-focuses on things or ideas. ___Yes ___No
57. My child has been diagnosed with **ADD** or **ADHD.** ___Yes ___No

## Part 3: Self-Help Information

58. My child can **independently**: (check all that apply)

___Put away toys ___Hang up coat ___Completely get dressed
___Clean up a spill ___Follow a 2-step direction ___Take care of all toileting needs
___Put shoes on correct feet ___Blow or wipe nose without being asked ___Ask an adult for help, when needed
___Wash hands ___Brush teeth ___Drink from an open cup (not sippy)

59. Is your child toilet-trained? ___Yes___No *If yes, for how long?*_____

## Part 4: Social Development Information

60. My child initiates play with other children. ___Yes ___No
61. My child has opportunities to play with other children his/her own age. ___Yes ___No
62. My child easily separates from parents. ___Yes ___No
63. My child is able to take turns. ___Yes ___No
64. My child gets along well with other children. ___Yes ___No
65. My child is fearful/anxious and worries a lot. ___Yes ___No
66. Does your child exhibit any serious behavior problems? (Check those that apply).

___Defiance of adults/non-compliant ___Excessive, long-lasting tantrums ___Biting
___Aggressive/violent behavior towards others ___Other:_____

67. What is your child's reaction to stress? (Check all that apply)

___Cries ___Headache ___Stomachache ___Bites ___Other:_____

**Discipline**

68. Are there challenges with behavior management at home? ___Yes ___No
    *If yes, what is the most effective in establishing acceptable behavior*:_____
    _____
    _____

69. My child's **strengths** are:_____
    _____
    _____
    _____

70. There is additional information that I would like to share. ___Yes ___No
    _____
    _____
    _____
    _____
    _____