

**Blind Brook – Rye Union Free School District
Bruno M. Ponterio Ridge Street School
Rye Brook, New York 10573**

PARENT QUESTIONNAIRE FOR PRE-KINDERGARTEN VISITATION

This questionnaire was designed so that our staff (teachers, the school nurse, and other professionals) can get to know your child better. In getting to know your child and the other children, we can better meet the needs of your child, as well as provide a balanced Kindergarten class for your child to attend next year. Your time spent in providing this information is much appreciated. (Please print.)

I. FAMILY INFORMATION

Name of child: _____ Date of Birth: ____/____/____
(Last) (First) mm dd yy

By what name would you like your child called: _____

Sex: ____F ____M

Address: _____ Home phone: _____

Mother's name: _____ Address (if different): _____

Occupation: _____ Work phone: _____

Father's name: _____ Address (if different): _____

Occupation: _____ Work phone: _____

Siblings (names & birth dates): _____

Relatives and others living with the family:

What is the primary language spoken in the home: _____

Is there a second language spoken in the home? ____Yes ____No

Language: _____

II. FAMILY HISTORY

A. Is there a history of learning difficulties in the family? ____ Yes ____ No

If yes, please describe _____

B. Has there been a death, divorce or separation, serious illness, or other experience during the past few years that might have affected your child? ____ Yes ____ No If yes, please describe: _____

1. If parents are divorced, what is the custody arrangement? _____

2. Please give instructions on how the school staff should handle school mailings to the other parent and phone calls or personal visits from her/him: _____

PLEASE PROVIDE THE SCHOOL WITH ALL LEGAL DOCUMENTS PERTAINING TO SCHOOL COMMUNICATION AND CUSTODY ARRANGEMENTS PRIOR TO THE START OF THE SCHOOL YEAR.

III. SKILLS

A. Does your child show a preference for left or right handedness?

____ Left ____ Right ____ No preference

B. Are there other specific skills or creative assets or talents that you wish to indicate?

IV. LANGUAGE

- A. At what age did your child start to say words? _____
- B. At what age did you first notice that your child put two or three words together in a sentence? _____
- C. How would you describe your child's spoken language at present? (please check)
 - _____ easily understood by all
 - _____ strangers sometimes have difficulties in understanding what she/he says
 - _____ can only be understood by family members
 - _____ family members, at times, find it difficult to understand him/her
- D. Do you have any reason to believe your child has any language or speech articulation problems? _____Yes _____No If yes, please describe: _____

- E. Does your child understand and respond when she/he is told to do something? (please check)
 - _____ most of the time
 - _____ sometimes
 - _____ seldom
- F. Does your child have any difficulty in telling a story or relating an experience?
_____Yes _____No If yes, please describe: _____

V. HOME AND CHILD RELATIONSHIPS

- A. What approaches have you found that work best with your child? How have you found you have been most effective in teaching your child? _____

- B. How does your child usually react when she/he becomes frustrated and how do you handle this? _____

C. How does your child get along with his/her brothers or sisters, if any? _____

VI. PLAY HABITS

A. Does your child prefer to: (please check)

- _____ play alone
- _____ play with older children
- _____ play with younger children
- _____ play with children the same age as her/him
- _____ be with adults rather than other children

B. What types of play does your child prefer? _____

C. He/She shares possessions with others...

- _____ readily
- _____ sometimes
- _____ with difficulty

VII. ATTITUDES AND INDEPENDENCE

A. How does your child feel about going to school? _____

B. How does she/he behave in your absence? _____

C. Has your child ever expressed separation anxiety? _____ Yes _____ No
If yes, please describe _____

VIII. Preschool/Daycare Experience

A. Did your child attend pre-school or day care? _____ Yes _____ No

1. Name of pre-school/day care: _____

Dates of attendance: _____ Teacher's name: _____

How many days per week? _____ Hours per day? _____

May we contact the school? _____ Yes _____ No Phone number: _____

2. Name of pre-school/day care: _____

Dates of attendance: _____ Teacher's name: _____

How many days per week? _____ Hours per day? _____

May we contact the school? _____ Yes _____ No Phone number: _____

B. Please describe his/her adjustment to the pre-school/day care experience: _____

C. Has your child ever been evaluated and/or received services through CPSE or privately?

_____ Yes _____ No If yes, please

describe: _____

Name of Provider/Agency _____ Phone number _____

Name of Provider/Agency _____ Phone Number _____

IX. Transportation

A. Are you planning to have your child take a bus to school?

_____ Yes, the district bus

_____ No

_____ I'm not sure

B. If you are planning on carpooling, please provide the names of probable riders:

X. CALL-BACK DAYS

During the first six weeks of the school year, your child will be attending Kindergarten for two whole days (call-back days) and three half days. Which call back days would you prefer?

_____ Monday/Tuesday

_____ Wednesday/Thursday

_____ No preference – either one would be fine

The next two pages will provide Mrs. Kalish, the school nurse, with valuable medical information about your child. Thank you for your time and patience in completing our questionnaire!

NAME: _____

XI. PHYSICAL AND HEALTH INFORMATION

A. Are there any special health conditions or chronic illnesses that your child has that the school should be aware of? If so, please describe _____

B. Does your child have asthma? _____Yes _____No

C. Does your child receive medication on a regular basis? _____Yes _____No

If yes, what medication? _____

Will it be necessary for your child to receive it during school hours? _____Yes _____No

D. Does your child have frequent colds, ear infections, or tubes? _____Yes _____No

If yes, please describe: _____

E. Does your child have any allergies to foods, medicine, animals, etc?

_____Yes _____No

If yes, please describe: _____

F. Should there be any restriction on your child's activity (e.g. running, jumping) due to a medical condition such as asthma, a heart condition, or something else?

_____Yes _____No If yes, please describe: _____

F. Do you have any reason for believing your child has a vision or hearing problem?

_____Yes _____No If yes, please describe: _____

G. Does your child receive a yearly check-up by your family...

doctor? _____Yes _____No Doctor's name: _____

dentist? _____Yes _____No Dentist's Name: _____

XII. MEDICAL HISTORY

A. Was your child born: Prematurely Post-maturely
 On time By C-Section

B. What was your child's birth weight? _____

C. Was your child in an incubator after birth? Yes No How long? _____

D. Was your child released from the hospital after his/her birth at the same time that his/her mother was? Yes No

E. Was there a feeding problem? Yes No

If yes, please describe _____

F. Did your child cry excessively or not at all as a baby? Yes No

If yes, please describe _____

G. Did your child have any serious illness or high fever as a baby? Yes No

If yes, please describe _____

H. Were there any pre-natal circumstances such as: RH factor, high/low blood pressure, medication, etc.? Yes No

If yes, please describe _____

I. Has your child had any of the following :

seizures recurrent headaches recurrent abdominal pains

sleepwalking breath holding spells night terrors

dizziness staring episodes ticks

muscle jerks fainting bathroom issues

other (please describe) _____

J. Has your child ever been hospitalized? Yes No

When? _____

Reason _____

K. Did your child ever swallow any medications or poisons accidentally? Yes No

Please describe _____

L. Did your child ever receive a head injury? Yes No

Please describe: _____

M. Has your child had any of the following? Please indicate the date or circle NO.

| | | | |
|---------------------|----|---------------------|----|
| Epilepsy_____ | NO | Anemia_____ | NO |
| Bronchitis_____ | NO | Chicken Pox_____ | NO |
| Pneumonia_____ | NO | Fifths Disease_____ | NO |
| Lyme's Disease_____ | NO | Scoliosis_____ | NO |
| Tuberculosis_____ | NO | Kidney Disease_____ | NO |
| Meningitis_____ | NO | Other_____ | |
| Hepatitis_____ | NO | | |

N. Is there any other medical information that the school would find helpful to know? _____

CHILD'S NAME _____

Permission Slip

I give my permission for the BMP-RSS kindergarten staff to speak to the teachers at

(Name of preschool/daycare)

(telephone number)

about my child's preschool/daycare experience.

(Signature)

(Date)