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:_____

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

Occupation:_____ Work phone:_____

Parent'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. 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

B. Do you have any reason to believe your child has any language or speech articulation problems? _____Yes _____No If yes, please describe:_____

_____

C. Does your child understand and respond when she/he is told to do something? (please check) _____ most of the time

_____ sometimes

_____seldom

D. Does your child have any difficulty in telling a story or relating an experience?

_____Yes _____No If yes, please describe:_____

_____

V. 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. He/She shares possessions with others…

_____ readily _____sometimes _____with difficulty

C. How does your child get along with other peers?

_____

_____

VI. ATTITUDES AND INDEPENDENCE

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

_____

B. Has your child ever expressed separation anxiety? _____Yes _____No

If yes, please describe_____

_____

VII. 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 (i.e., speech/language, OT, PT, SEIT, social skills):

_____

_____

_____

Name of Service _____

Name of Provider/Agency_____

Phone number _____

Name of Service _____

Name of Provider/Agency_____

Phone number _____

The next 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: _____

X. 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:_____

_____

If an epi pen is required, does it stay in the classroom or in the nurse's office?

Classroom _____ Nurse's Office _____

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:_____

XI. 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?_____

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

D. Was there a feeding problem? ____Yes ____ No
If yes, please describe_____

E. Did your child cry excessively or not at all as a baby? ____Yes ____ No
If yes, please describe_____

F. 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?_____

_____

_____

_____

_____

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