Summerbrook ChildCARE

Parent/Student Questionnaire
PreK-Kindergarten

Student's Name: _____ Entering Grade: _____

Who is completing this Parent Questionnaire? Mother Father Guardian Other

FAMILY INFORMATION

Student Family Info: Traditional Blended Single Parent Other _____
With whom has the child lived for most of the past year? _____
Other Children in the family- How many older? _____ How many younger? _____
Other People Living in the Household? _____

PRESCHOOL/CHILD CARE HISTORY

Has your child attended preschool/child care before? Yes No
If yes, for how long? _____

MEDICAL HISTORY

Were there any significant problems during pregnancy? Yes No
If yes, explain: _____
Was your child more than 3 weeks premature? Yes No
If yes, how many weeks premature? _____
Did the baby stay in the hospital longer than the mother? Yes No
If yes, explain: _____

EYES

Has your child ever had trouble seeing? Yes No
Does your child hold books and objects close to his or her face? Yes No
Does your child wear glasses to help vision? Yes No
Has your child had any other vision problems? Yes No
If yes, explain: _____

EARS

Has your child had frequent ear infections? Yes No
Has your child ever had trouble hearing? Yes No
If yes, explain: _____

COORDINATION

Has your child ever had trouble walking, climbing, reaching, holding on to things? Yes No
If yes, explain: _____

GENERAL MEDICAL

Has your child ever had any significant injuries or hospitalizations? Yes No
If yes, explain: _____

GENERAL MEDICAL (CONTINUED)

Does your child have allergies? Yes No

If yes, describe: _____

Is your child presently on any medications? Yes No

If yes, please describe: _____

Please describe any other health concerns: _____

_____

CHILD'S DEVELOPMENT

Can your child-

feed him or herself using a spoon and/or fork?	Yes	No
wash and dry his or her own hands?	Yes	No
help with dressing or dress with little assistance?	Yes	No
stay with a babysitter?	Yes	No
speak so that he or she can be understood by others?	Yes	No
express his or her thoughts and needs easily?	Yes	No

Do you have any concerns about your child's appetite or willingness to try different foods? Yes No

If yes, explain: _____

Do you have any concerns about your child's sleeping patterns?	Yes	No
Is going to bed at night difficult?	Yes	No
Does your child require a nap?	Yes	No

Is your child-

Highly active?	Yes	No
Very quiet?	Yes	No
Toilet trained? At what age? _____	Yes	No
In need of help with toileting?	Yes	No

Does your child-

Play with blocks or other construction toys without help?	Yes	No
Use crayons to scribble draw?	Yes	No
Listen to stories being read to him or her?	Yes	No
Turn pages of a book and look at pictures?	Yes	No
Recall stories or events?	Yes	No
Enjoy playing alone or with imaginary friends?	Yes	No
Talk with your friends/relatives who come to visit?	Yes	No
Follow simple, age-appropriate directions?	Yes	No
Have difficulty with separation?	Yes	No

What are your child's favorite activities? _____

_____

Does your child have opportunities to play with other children?	Yes	No

How many hours a day does your child spend watching TV/Computer? _____

Does he or she sit very close to the TV/Monitor?	Yes	No
Does he or she turn up the volume very high?	Yes	No

Are there any other things you would like to tell us about your child?

_____

_____

_____

_____