



## Pembroke Public Schools

72 Pilgrim Road, Pembroke, MA 02359

Ph: 781-829-0832 | Fax: 781-829-6957

[www.pembrokek12.org](http://www.pembrokek12.org)

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### KINDERGARTEN PARENT QUESTIONNAIRE

In kindergarten, a child prepares not only for his/her future years in school, but also for the rest of his/her life. In most instances, kindergarten children start school based on their age. However, all five-year-old children are not at the same level of development.

*Children are alike in many ways.  
Each goes through the same stages of growth,  
Yet each is different from all others.*

To allow us to get a more complete image of your child, your assistance is needed. Please complete the *Parent Questionnaire*. We ask that you answer the questions on this form as objectively as possible. **There are no right or wrong answers.** Your answers should be those that give an honest description of your child. Your responses to the questionnaire will be kept confidential.

This description, along with the information we'll receive during the Kindergarten Screening, will be of help to us. The team will utilize it as we determine our recommendations about which is the best educational environment for your child for the coming school year. Thank you for taking the time to provide us with this information.

**PLEASE RETURN THE COMPLETED QUESTIONNAIRE WITH YOUR CHILD'S REGISTRATION PAPERWORK.**



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## KINDERGARTEN QUESTIONNAIRE

Child's name: \_\_\_\_\_ Birth date: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_

Address: \_\_\_\_\_ City/province: \_\_\_\_\_ Postal code: \_\_\_\_\_

Phone: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Your careful completion of this questionnaire, which will help us to assess this child's needs, is greatly appreciated. Who is completing the Parent Questionnaire? \_\_\_\_\_

Relationship to Child \_\_\_\_\_

### FAMILY

With whom has the child lived with for most of the past year? \_\_\_\_\_

Other children in the family- How many older? \_\_\_\_\_ How many younger? \_\_\_\_\_

Other people living in the household

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What language(s) are spoken at home?  English  Other (Specify) \_\_\_\_\_



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## PRESCHOOL/CHILD CARE HISTORY

Has your child attended preschool/childcare before? No  Yes

If yes, for how long? Circle One SIX MONTHS ONE YEAR TWO YEARS MORE THAN TWO YEARS

Name of child's present or most recent school?

\_\_\_\_\_

## MEDICAL HISTORY

Were there any significant problems during your pregnancy? No  Yes

If yes, please explain?

\_\_\_\_\_

\_\_\_\_\_

Was your child more than 3 weeks premature? No  Yes

If yes, how many weeks premature?

\_\_\_\_\_

Baby's birth weight: \_\_\_\_\_

\_\_\_\_\_

Did the baby stay in the hospital longer than the birth mother? No  Yes

If yes, please explain:

\_\_\_\_\_

\_\_\_\_\_

At the time of birth, did the baby- Have seizures? No  Yes  Turn blue? No  Yes

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## CHILD'S HEALTH SINCE BIRTH

Please select one:	YES	NO
<b>EYES</b>		
Has your child ever had trouble seeing?		
Does your child hold books and objects close to his or her face?		
Have your child's eyes ever looked crossed?		
Have you ever suspected that your child has vision problems?		
If yes, please explain		
<b>EARS</b>		
Has your child had frequent ear infections?		
Has your child ever had trouble hearing?		
Have you ever suspected that your child has a hearing problem?		
If yes, please explain		
<b>COORDINATION</b>		
Has your child ever had trouble walking, climbing, reaching, holding onto things?		
If yes, please explain		



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## CHILD'S HEALTH SINCE BIRTH Continued

Please select one:	YES	NO
Has your child ever had any significant injuries or hospitalizations?		
If yes, please explain		
Does your child have allergies?		
If yes, please explain		
Is your child presently on any medications?		
If yes, please explain		
Please describe any other health concerns:		



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## SOCIAL, EMOTIONAL, AND SELF-HELP SKILLS

Please select one:	YES	NO
<b>CAN YOUR CHILD</b>		
feed him or herself using a spoon and/or fork?		
wash and dry his or her own hands?		
dress with little assistance?		
stay with a babysitter/another caregiver?		
speak so that he or she can be understood by others?		
express his or her thoughts and needs easily?		
<b>DO YOU HAVE ANY CONCERNS ABOUT</b>		
your child's willingness to try different foods?		
If yes, please explain		
your child's sleeping patterns (going to bed with difficulty, or waking often during the night?)		
If yes, please explain		



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## SOCIAL, EMOTIONAL, AND SELF-HELP SKILLS continued

Please select one:	YES	NO
<b>IS YOUR CHILD</b>		
Highly active?		
Very quiet?		
Toilet trained during the day?		
In need of help with toileting?		
<b>DOES YOUR CHILD</b>		
Play with blocks, boxes, cups, and other construction toys without help?		
Use crayons and/or markers to scribble and draw?		
Listen to stories being read?		
Turn pages of a book and look at pictures?		
Recall stories or events?		
Enjoy playing alone or with imaginary friends?		
Talk with your friends/relatives who come to visit?		
Follow simple, age-appropriate directions?		

<b>WHAT ARE YOUR CHILD'S FAVORITE ACTIVITIES?</b>



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Please select one:	YES	NO
<b>DOES YOUR CHILD</b>		
Have opportunities to play with other children?		
How many hours a day does your child spend watching tv?		
Does he or she sit very close to the tv?		
Does he or she turn the volume up very high?		





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**PLEASE ASSESS YOUR CHILD IN THE FOLLOWING AREAS:**

**PERSONALITY TRAITS**

Please select one:	YES	NO
Does your child cry easily?		
Need a great deal of reassurance?		
Have temper tantrums?		
Does your child stay with other people reluctantly?		
Does your child stay with other people easily?		
Is your child a worrier?		
Is your child hard to handle?		
Is your child fearful?		
Does your child fear (dark, storms, doctors, animals, etc.)		
What type of discipline would your child respond to best in school?		
My child can manage how he/she feels and tell about his or her feelings (circle one)		
most of the time	some of the time	with some adult support



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**PLEASE ASSESS YOUR CHILD IN THE FOLLOWING AREAS continued:**

Skill set	Major concern	Minor concern	No concern	Cannot judge	Comments
<b>SOCIAL SKILLS</b>					
Interest in peers					
Initiation of interactions with peers					
Social responses to peers					
Group play with peers					
Imaginative play					
Solitary play					
Repetitive motor movements or behaviors (spinning, flapping, tics)					
Ability to share					
Turn-taking					
Offering comfort					
Compliance with rules and limits					
Adjustment to new or changed routines					



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**PLEASE ASSESS YOUR CHILD IN THE FOLLOWING AREAS continued:**

Skill set	Major concern	Minor concern	No concern	Cannot judge	Comments
<b>BEHAVIOR</b>					
Attention span					
Impulsivity					
Hyperactivity or motor restlessness					
Physical aggression					
Destructive tendencies					
Temper tantrums					
Breath-holding spells					
Unusual fears					
Obsessive interests/ topics					
Ritual behaviors					
Phobias					
Somatic complaints (stomach aches, headaches, pains)					
Difficult temperament/ moods					
Other (specify)					
<b>RECEPTIVE LANGUAGE SKILLS</b>					
Following 1-step instructions					
Following 2-step instructions					
Listening in a group					
Listening to stories					

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Listening to rhymes and tunes					
Other (specify)					
<b>EXPRESSIVE LANGUAGE SKILLS</b>					
Pronunciation					
Speaking in phrases/sentences					
Taking turns in conversation					

Has there been a deterioration, loss, or plateauing of previously acquired skills in the past year? No  Yes

If yes, please explain: \_\_\_\_\_

<b>ARE THERE OTHER THINGS YOU WOULD LIKE TO TELL US ABOUT YOUR CHILD?</b>

Please attach copies of the child's latest assessment or progress reports and include any other information that might help in assessment of this child.

**THANK YOU FOR COMPLETING THIS QUESTIONNAIRE.**

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