

Kindergarten Registration Questionnaire

Name of Child \_\_\_\_\_ Date of Birth \_\_\_\_\_

Name child likes to be called \_\_\_\_\_

Father's Name \_\_\_\_\_ Mother's Name \_\_\_\_\_

Child lives with: (check all that apply)

- mother             father             step-mother             step-father
- grandmother     grandfather     foster parents
- other (please specify) \_\_\_\_\_

Has your child attended school before: (pre-school, daycare, Head Start, etc.)  yes  no

If so, where? \_\_\_\_\_ How long? \_\_\_\_\_

Check below any services that your child has received:

- speech and language therapy     hearing services
- vision therapy                       occupational therapy
- physical therapy                     counseling

What activities does your child enjoy? \_\_\_\_\_  
\_\_\_\_\_

Do you have any concerns about your child? Please check and explain any that relate to him/her:

- hearing                       vision                       speech
- development               general health               behavior

Comments/explanation: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are there any tasks that you anticipate your child may have difficulty with when starting kindergarten? (such as separating from family to come to school, toileting tasks, following directions, etc.)

yes             no            If yes, what are those difficulties?

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

Is there any information you would like to share with us that would ensure your child's success in school? \_\_\_\_\_

\_\_\_\_\_

Parent's Signature: \_\_\_\_\_ Date: \_\_\_\_\_