



BROOKSIDE • HIDDEN VALLEY • MANOR • WADE THOMAS • WHITE HILL

## TRANSITIONAL KINDERGARTEN / KINDERGARTEN STUDENT INFORMATION

Parent/Guardian, please complete the following questionnaire to help us become better acquainted with your child.  
For School Year: \_\_\_\_\_

1. Child's Name: \_\_\_\_\_ Gender \_\_\_\_ Date of Birth \_\_\_\_\_

2. Parent/Guardian Name(s) (Child lives with): \_\_\_\_\_

Circle relationship: Mother/s Father/s Stepfather Stepmother Guardian Custodian

3. Address: \_\_\_\_\_ Phone # \_\_\_\_\_

4. Parent/Guardian Name(s) (Child does not live with): \_\_\_\_\_

5. Circle Relationship: Mother/s Father/s Stepfather Stepmother Guardian Custodian

Address: \_\_\_\_\_ Phone # \_\_\_\_\_

6. Parent/Guardian Work Information:

Name \_\_\_\_\_

7. Relationship \_\_\_\_\_ Work Phone # \_\_\_\_\_

Employed by (name & address): \_\_\_\_\_

8. Name \_\_\_\_\_

9. Relationship \_\_\_\_\_ Work Phone # \_\_\_\_\_

Employed by (name & address): \_\_\_\_\_

10. Do you speak another language other than English in your home? Yes \_\_\_\_\_ No \_\_\_\_\_

If 'yes', which language? \_\_\_\_\_

11. If you want your child to be known by a shortened variation or nickname rather than his/her "formal" name, please write the name here \_\_\_\_\_

12. Names and ages of siblings: \_\_\_\_\_

\_\_\_\_\_

13. What does your child's bedtime routine look like? \_\_\_\_\_

\_\_\_\_\_

14. What responsibilities does your child have at home (ie. dressing oneself, picking up toys, etc.)?

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15. What types of consequences and incentives do you use to redirect your child's behavior?

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16. Does your child having any diagnosed disability which could affect his/her learning (examples: ADD, autism or other spectrum disorder, physical disability, sensory processing disorder)?

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17. Is there another child your child learns best with and/or should be separated from?

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18. Has your child had pre-school experience? Yes \_\_\_\_\_ No \_\_\_\_\_

If Yes, how many hours per day? \_\_\_\_\_ At what age did s/he begin? \_\_\_\_\_

Name of Pre-School \_\_\_\_\_

Name of teacher \_\_\_\_\_ School Phone # \_\_\_\_\_

19. If no pre-school experience, has your child had childcare experience? Yes \_\_\_\_\_ No \_\_\_\_\_

20. What does your child like to do at home? \_\_\_\_\_

at pre-school or with childcare? \_\_\_\_\_

21. What is your child's order of birth in your family? \_\_\_\_\_

22. What pleases you most about your child's development? \_\_\_\_\_

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23. What concerns you most about your child's development? \_\_\_\_\_

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24. How does your child feel about coming to Transitional Kindergarten/Kindergarten?

Apprehensive? \_\_\_\_\_ Not sure? \_\_\_\_\_ Excited? \_\_\_\_\_

Comment(s) \_\_\_\_\_

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25. Dominant Side

Left \_\_\_\_\_ Right \_\_\_\_\_ Ambidextrous \_\_\_\_\_

26. What are your expectations for your child's Transitional Kindergarten/Kindergarten experience?

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