

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: _____