Southern Fulton School District
Kindergarten Questionnaire

FAMILY BACKGROUND: DATE:_____

CHILD'S NAME_____

THE NAME YOU WANT YOUR CHILD CALLED:_____

BIRTHDAY_____ HOME PHONE_____
month/day/year

ADDRESS_____

FATHER'S NAME_____OCCUPATION_____

EMPLOYER_____

MOTHER'S NAME_____OCCUPATION_____

EMPLOYER_____

CURRENT MARITAL STATUS: Married_____ Divorced_____
Separated_____ Single_____

CHILD LIVES WITH:_____

OTHER SF DISTRICT CHILDREN IN FAMILY	AGE	GRADE IN SCHOOL
_____	____	_____
_____	____	_____
_____	____	_____
_____	____	_____

HAS THERE BEEN A DIVORCE, DEATH, OR ILLNESS IN THE FAMILY
WHICH MIGHT AFFECT YOUR CHILD: YES OR NO COMMENTS:____

_____

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SOCIAL EXPERIENCE:

HAS YOUR CHILD ATTENDED PRE-SCHOOL? _____ IF SO, WHICH ONE?_____

FOR HOW LONG? _____HOW MANY DAYS A WEEK?_____

DO YOU READ TO YOUR CHILD?_____

HAS YOUR CHILD HAD EXPERIENCES WITH:

CRAYONS?_____SCISSORS? _____

CAN YOUR CHILD:

DRESS HIM/HER SELF?_____

TIE SHOE LACES?_____

PUT ON BOOTS?_____

USE BATHROOM UNASSISTED?_____

DOES YOUR CHILD MAKE REPEATED TRIPS TO THE BATHROOM?_____

CHILD DEVELOPMENT:

DOES YOUR CHILD HAVE ANY HEALTH PROBLEMS THE SCHOOL SHOULD BE AWARE OF? IF SO, WHAT?_____

_____

_____

PLEASE LIST ANY MEDICATIONS YOUR STUDENT TAKES ON A DAILY BASIS (OPTIONAL)_____

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DOES YOUR CHILD HAVE FREQUENT ILLNESSES SUCH AS :
EARACHES, INFECTIONS, HEADACHES, NOSE BLEEDS, OR HAS HAD SURGERY? PLEASE EXPLAIN_____

_____

_____

DOES YOUR CHILD HAVE ANY FOOD ALLRGIES?_____

_____

IS YOUR CHILD A PROBLEM EATER?_____

DOES YOUR CHILD HAVE ANY OTHER ALLERGIES?_____

IS YOUR CHILD RIGHT-HANDED OR LEFT-HANDED?_____

IS YOUR CHILD ABLE TO SEPARATE EASILY FROM THE PARENTS?____

DOES YOUR CHILD HAVE ANY FEARS?_____

_____

HOW DOES YOUR CHILD FEEL ABOUT STARTING SCHOOL?_____

_____

******EMERGENCY INFORMATION******

IN CASE OF ILLNESS, ACCIDENTS, OR EMERGENCY; WHOM SHOULD WE CALL, IF YOU CAN'T BE REACHED?

NAME	PHONE NUMBER
_____	_____
_____	_____
_____	_____