VALLEY VIEW PRIMARY SCHOOL
Kindergarten Questionnaire

Family Background

Child's Full Name _____

Name/Nickname to be written and used in school _____

Birthday ☐☐ Month ☐☐ Day ☐☐☐☐ Year Sex M F

Address _____
Street City Zip

Primary Phone Number _____

Email Address _____

Mother/Guardian's Name _____

Address (if different from child's) _____

Occupation _____

Father/Guardian's Name _____

Address (if different from child's) _____

Occupation _____

With whom does the child reside _____

List all adults in the primary household

_____

_____

_____

_____

List all siblings in the household
(include age/grade for upcoming school year)

_____

_____

_____

_____

Does child have a secondary address (If yes, please state below and include frequency)

_____

List all adults and children at that address

_____

_____

General Information

Has your child attended PreSchool ☐ Yes ☐ No

If yes, name of PreSchool _____

City of PreSchool _____

Describe your child's preschool background (frequency, hours per day, number of years, etc.)

_____

_____

_____

Is your child ☐ right-handed ☐ left-handed

Can they print their first name? ☐ Yes ☐ No

Do you celebrate birthdays and holidays ☐ Yes ☐ No

Does your child have any health concerns the teacher should be aware of (such as asthma, vision/glasses, serious illness in the past, etc.)?

_____

_____

Does your child have any food allergies?

_____

Is there anything you would like your child's teacher to know about your child?

_____

_____

BEHAVIOR/TEMPERAMENT

Child's Name (please print): _____

Please indicate whether your child exhibits any of the following behaviors:

	YES	NO
Gets overly "wound up" in play		
Has trouble "shifting gears" or changing from one thing to another		
Has a short attention span		
Seems unhappy or negative about things		
Withholds affection		
Hides feelings		
Has trouble sitting through an entire meal		
Has fears		
Seems impulsive		
Overacts when faced with a problem		
Seems uncomfortable meeting new people		
Requires a lot of parental attention		
Cannot calm down		
Fights frequently with playmates		
Prefers to play alone		

Other concerns

_____

_____

_____

Ohio Department of Health • School and Adolescent Health

Health History

Student's name	Sex	Date of birth
	☐ Male ☐ Female	/ /

Family Health History Please list allergies, heart problems, diabetes, cancer or other serious health conditions.

Father
Mother
Brothers and Sisters

Birth and Developmental History ☐ No unusual birth or developmental history

Did the mother have any unusual physical or emotional illness during this pregnancy? ☐ Yes ☐ No

Was infant born full term? ☐ Yes ☐ No Did the infant have any sickness or problems? ☐ Yes ☐ No

Briefly explain illness or problems.

How does the child's development compare to other children, such as his or her brothers/sisters or playmates?

☐ About the same ☐ Delayed ☐ Advanced

Student Health Conditions

☐ **YES,** my child receives regular medical/health care for the following conditions: ☐ **NO** medical conditions

☐ Allergies	☐ Diabetes	☐ Seizure disorder
☐ Asthma	☐ Depression	☐ Sickle cell anemia
☐ ADD/ADHD	☐ Ear problem/hearing difficulty	☐ Skin conditions
☐ Autism	☐ Emotional concerns	☐ Speech problems
☐ Behavior concerns	☐ Headaches	☐ Traumatic brain injury
☐ Birth/congenital malformations	☐ Heart problems	☐ Vision problems (glasses, contacts)
☐ Bone/muscle/joint problems	☐ Hemophilia	☐ Other_____
☐ Blood problems	☐ Juvenile arthritis	☐ Other_____
☐ Bowel/bladder problems	☐ Lead poisoning	☐ Other_____
☐ Cancer	☐ Migraines	☐ Other_____
☐ Cystic fibrosis	☐ Neuromuscular disorder	☐ Other_____

Please explain any conditions above or any reasons for hospitalizations.

Please indicate any allergies your child may have.

Allergy type	Reaction	School restrictions or recommended actions
☐ Bee/Insect		
☐ Food		
☐ Medication		
☐ Other		

Health History continued

Please list any prescription and over the counter medication that your child takes on a regular basis.

Medication and dose	Time	Reason

Do any health and/or medical conditions require school restrictions, modifications, and/or intervention?

☐ Yes ☐ No If YES, please explain.

Does the student require any special procedures and/or treatments for their health condition(s)?

☐ Yes ☐ No If YES, please explain.

Please indicate any other information about your child's health or development that you think would be helpful for the school to know.

Form completed by	Relationship to student	Date
		/ /