

## Kindergarten Parent Interview Form

### Student Information

Child's Full Name	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Non-binary
Does your child have a preferred name?	Date of Birth
Is there a language in addition to or other than English spoken in your home? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what is/are the language(s) _____	

Parent/Legal Guardian Name	Relationship to child <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other _____
Working Hours	

Parent/Legal Guardian Name	Relationship to Child <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other _____
Working Hours	

Parents/Legal Guardians  
 Married  Single  Widowed  Divorced  Separated

If parents are not together, child's age at separation \_\_\_\_\_  
 Briefly describe custody arrangement \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

### Child's Household Includes (Please include the ages of children/siblings in the household)

Name	Relationship	Age of Child

### Educational Services and Needs

Does your child receive services for special needs? If yes, please describe. \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Have any members of the family been diagnosed with dyslexia or had any other learning problems?  
 Mother  Yes  No      Father  Yes  No  
 Sibling  Yes  No      Other Family Member  Yes  No  
 Please explain \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Educational Services and Needs Continued				
My Child				
Hears normally	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Has a history of frequent ear infections	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Has had tubes placed in his/her ears	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Learns new words easily and naturally	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Was later in learning to speak and slow to acquire new words	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Knows nursery rhymes or song lyrics that rhyme	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Can recognize and produce rhymes.	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Often mispronounces words, like saying "beddy tear" instead of "teddy bear."	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Developmental and Health History				
Was the pregnancy and birth routine? If not, briefly describe.				
Approximate age at which your child:				
Crawled _____ Walked _____ Spoke words _____ Spoke in phrases _____				
Do you have any health concerns (allergies, asthma, ear infections, vision, etc.) about your child? If yes, please explain.				
When does your child go to bed and wake up?				
Does your child go to sleep easily?				
1 Always	2 Very Often	3 Sometimes	4 Rarely	
Does your child sleep well?				
1 Always	2 Very Often	3 Sometimes	4 Rarely	
Does your child take a nap?				
1 Always	2 Very Often	3 Sometimes	4 Rarely	
Is your child physically active?				
1 Always	2 Very Often	3 Sometimes	4 Rarely	
How is your child's coordination?				
1 Excellent	2 Good	3 Fair	4 Poor	
How is your child's concentration?				
1 Excellent	2 Good	3 Fair	4 Poor	

Social/Emotional History

How does your child react to new situations?

What have you found is the best way to work with your child when they are upset?

What techniques do you use to help your child comply with requests?

Does your child have any fears you would like us to know about?

Has your child experienced any significant losses? If yes, please explain.

How independent is your child? (e.g., follows directions, plays alone, separates from adults, self-help, etc.)

- |                   |          |             |            |
|-------------------|----------|-------------|------------|
| 1                 | 2        | 3           | 4          |
| To a Great Extent | Somewhat | Very Little | Not at All |

Experiences, Interests and Other Information

What organized group experiences have/has your child participated in? Check all that apply

- Preschool      Full Name of Preschool: \_\_\_\_\_
- Daycare
- Camp
- Religious School
- Group Lessons (please specify) \_\_\_\_\_
- Other (please specify) \_\_\_\_\_

Does your child get along with children?

- |                 |              |                  |            |
|-----------------|--------------|------------------|------------|
| 1               | 2            | 3                | 4          |
| All of the Time | Most of Time | Some of the Time | Not at All |

Experiences, Interests and Other Information Continued

My child primarily plays

- Alone
- With Siblings
- With Younger Children
- With Relatives
- With Older Children
- With Children the Same Age

Did your child experience any difficulty in preschool? Is yes, please describe.

What does your child like to do?

What are your child's special qualities and strengths?

Is there any additional information that you think the school should have?

Thank you for helping us to get to know your child. We appreciate the time and effort you have taken to complete this form.

For School Use Only

Person Interviewed \_\_\_\_\_

Relationship to Child \_\_\_\_\_

Interviewer \_\_\_\_\_

Date \_\_\_\_\_