Fountain • Fort Carson
SCHOOL DISTRICT EIGHT

FOUNTAIN-FORT CARSON SCHOOL DISTRICT 8

KINDERGARTEN QUESTIONNAIRE

Please note that any out-of-district requests may require follow-up from administration.

PLEASE PRINT

Child: _____ Date of Birth: _____ Gender: **M / F**
First Name Middle Name Last Name

Address: _____ City: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Child's Primary Language: _____

Current Pre-School or Day Care Provider Name: _____

Current Pre-School or Day Care Provider Phone Number: _____

Medical History:

Has your child had any of the following (check all that apply)?

_____Upper Respiratory Infections	_____Bone/Orthopedic Problems	_____Sleeping Problems
_____Allergies	_____Head Injuries/Unconsciousness	_____Dental Problems
_____Frequent Ear Infections	_____Convulsions/Seizures	_____High Fever
_____Feeding/Eating Tubes	_____Weight Problems	_____Frequent Sore Throat
_____Stomachaches	_____Bladder/Kidney Problems	_____Asthma
_____Heart Problem/Condition	_____Emotional Problems	_____Frequent Nose Bleeds
_____Surgery	_____Significant Accident/Injury	_____Anemia

Please explain any of the above: _____

_____

How is your child's health now? **Excellent / Good / Fair / Poor**

Explain any health concerns: _____

_____

Does your child have a known medical diagnosis? **YES / NO** If yes, what is the diagnosis? _____

Is your child taking any medication? **YES / NO** Please list: _____

Are your child's shots up to date? **YES / NO**

Does your child have any food allergies? **YES / NO** Please explain: _____

Developmental Information:

(In the following areas, please check whether your child was early, average or late in developing)

	Early	Average	Late		Early	Average	Late
Turned Over				**Walked Alone**			
Smiled at Parents				**Fed Self**			
Sat alone				**Said "no,no" to everything**			
Crawled				**Used Sentences**			
Said First Word				**Stayed Dry During Day**			
Helped with Dressing				**Stayed Dry During Night**			
Drank from a Cup				**Dressed Alone**			

Concerns noted by your child's pediatrician:

Social History and Functioning:

Does your child currently attend a preschool or childcare? **YES / NO** If yes, where? _____

Describe your child's relationship with caregivers: _____

Describe how your child separates from caregivers: _____

Describe your child's relationship with siblings: _____

Describe your child's strengths: _____

What worries you about your child's social functioning? _____

What does your child enjoy? _____

What bothers your child? _____

Do you have questions or concerns about your child's behavior? **YES / NO** Please explain: _____

_____

Identify the behaviors below that your child displays that you believe are atypical: (check any that apply)

☐ Impulsive	☐ Distractible	☐ Prefers to Play Alone	☐ Rocks	☐ Shy or Timid
☐ Has Temper Tantrum	☐ Show Dare-Devil Behavior		☐ Stubborn	☐ Clumsy
☐ Doesn't Pay Attention	☐ Easily Frustrated	☐ Daydreams	☐ Moody	☐ Falls a lot
☐ Avoids Attention	☐ Dislikes Changes	☐ Hits Caregivers	☐ Has Fears	☐ Holds Breath
☐ Bangs Head	☐ Is Aggressive to others			

Additional Information: _____

_____

Relevant Family Information:

What major changes have occurred in your family or child's life over the last year? _____

_____

How many times has your family moved in the last year? _____

What activities does your family like to do together? _____

_____

Relatives or other individuals who are available to support your family: _____

_____

I AM THE LEGAL GUARDIAN OF THIS CHILD AND CERTIFY THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THE DISTRICT MAY CONTACT PRESCHOOL AND /OR DAYCARE PROVIDER.

Signature: _____ Date: _____

Reviewer Signature: _____ Date: _____