

Francis T. Bresnahan School

Parent Questionnaire

For Kindergarten Screening

"Where All Children Come First"

NEWBURYPORT PUBLIC SCHOOLS

Dear Parents:

Please take a few moments to introduce your child to us through this questionnaire. **The completed questionnaire is due at the time of registration.**

This form has four parts that ask for information about your child:

- Part 1: Personal background information about your child.
- Part 2: Health information about your child.
- Part 3: Self-Help Development about your child's ability to care for him/herself.
- Part 4: Social Development about how your child behaves with other people.

Please read through the form and respond to all items as carefully as you can. You are an important source of information about your child. The information and answers that you provide enable us to better understand the whole child. Information shared on this questionnaire will remain confidential and will only be shared with your child's classroom teacher and specialist teachers. We greatly appreciate your time in completing this form and look forward to working with you and your child.

Child's Name (First, Last):_____

Name child will be using in school:_____

Date of Birth: ____/____/____ Gender: ____Male ____Female

Parent 1/Guardian 1	Parent 2/ Guardian 2
Mr./Mrs./Ms./Other:_____	Mr./Mrs./Ms./Other:_____
Name (First/Last)_____	Name (First/Last)_____
Address:_____	Address:_____
City:_____ State:____ Zip:_____	City:_____ State:____ Zip:_____
Relationship to Child:_____	Relationship to Child:_____
Home Phone:_____	Home Phone:_____
Work Phone:_____	Work Phone:_____
Cell Phone:_____	Cell Phone:_____
Email for school contact:_____	Email for school contact:_____
Has custody of child? ☐ Yes ☐ No ☐ Joint	Has custody of child? ☐ Yes ☐ No ☐ Joint
Does child live with this parent? ☐ Yes ☐ No	Does child live with this parent? ☐ Yes ☐ No

Person completing this survey: ☐ Mother ☐ Father ☐ Guardian ☐ Caregiver ☐ Other (specify) _____

Part 1: Personal Information

Living Situation

1. Who does your child live with? (Check all that apply)

☐ Mother ☐ Father ☐ Stepmother ☐ Stepfather ☐ Mother's Partner ☐ Father's Partner
☐ Grandmother ☐ Grandfather ☐ Other relative (specify) _____
☐ Foster family: Case worker's name and phone #:_____
☐ Other (specify) _____

2. Is the child adopted? ☐ Yes ☐ No
3. If your child is adopted at what age did he/she join the family? _____

Siblings

4. Does your child have brothers or sisters? ☐ Yes (Please list below) ☐ No

Name of brother/sister	Age	Name of School Attending	Does this child live at home with your kindergartner?

5. My child's birth order in the family is ___ out of ___children.

Language

6. Language first spoken by your child:_____
7. Language child uses most often:_____
8. Language parents use most often:_____
9. Does your child understand and speak English? ☐ Yes ☐ Limited/Partially ☐ Not at all

School situation

10. What are your concerns about your child's schooling? _____
    _____
    _____
11. Has your child attended a preschool/ daycare? ☐ Yes ☐ No If yes, for how long? (years/months)_____
12. How many hours per week has your child most recently attended preschool or daycare? _____
13. What is the name and location of your child's preschool/daycare? _____
    Preschool or Daycare contact person's name: _____
14. May we have permission to contact the previous teacher/daycare provider? ☐ Yes ☐ No (If *yes, please sign below)*

Signature:_____Date:_____

Home Situation

15. When was the last time you moved? _____
16. How often have you moved in the last 5 years? _____
17. Have any of the following occurred?
    Parents separated or divorced ☐ Yes ☐ No When? _____
    A death or major loss ☐ Yes ☐ No Who/When_____
    Other major events that may have upset your child? _____
    _____Date:_____
18. Has your child reacted to any of the above situations with behaviors that concern you? _____
    _____
    _____

Part 2: Health Information

Birth Information

19. Was the child a full term baby? ☐ Yes ☐ No
20. Were there any complications with the pregnancy or at birth? ☐ Yes ☐ No
    If YES explain: _____

Medical/Health Information

21. Did your child receive Early Intervention Services? ☐ Yes ☐ No
    If YES, with whom? _____
22. Has your child seen an optometrist or ophthalmologist? ☐ Yes ☐ No
23. Does your child wear glasses? ☐ Yes ☐ No

Childs Name: _____

24. Do you suspect your child has a vision problem? ☐ Yes ☐ No
    Comments: _____
25. Do you suspect your child has a hearing problem? ☐ Yes ☐ No
    Comments: _____
26. Is your child under the care of an audiologist or ear, nose and throat (ENT) specialist? ☐ Yes ☐ No
27. Has your child had frequent ear infections? ☐ Yes ☐ No
28. Has your child had ear tubes inserted? ☐ Yes ☐ No
    If YES, at what age(s)? _____
29. Does your child speak loudly? ☐ Yes ☐ No
30. Does your child have a significant medical history due to an accident, illness or medical condition? ☐ Yes ☐ No
    If YES, please describe: _____
31. Has your child ever been hospitalized? ☐ Yes ☐ No
    If YES, please explain: _____
32. Does your child take prescription medications on a routine, daily basis? ☐ Yes ☐ No
    If YES, please list: _____
33. Does your child have any allergies? ☐ Yes ☐ No
    If YES, please list: _____
34. Does your child have an EPI PEN? ☐ Yes ☐ No
35. Does your child use an asthma inhaler? ☐ Yes ☐ No
36. Has your child ever had a special assessment for : (Please circle, if applicable)
    Educational exam **Psychological exam** **Neurological exam**
    If your child has had one of the above exams, please describe the reason(s):_____
    _____
    Name and location of person(s) who administered the exam: _____
    _____
37. Has your child ever experienced a major psychological trauma? ☐ Yes ☐ No
    If YES, please describe: _____
38. May we have permission to contact your child's medical provider, as needed? ___Yes ___No *If yes, please sign below*
    Medical provider's name: _____ Phone #:_____

    Signature:_____ Date:_____

Speech/Language Information

39. My child has had a **speech and language evaluation**. ☐ Yes ☐ No
    If YES, did he/she receive therapy? ☐ Yes ☐ No How long? _____
40. My child <u>currently</u> receives **speech and language therapy.** ☐ Yes ☐ No
    Therapist's name/agency: _____
41. My child is generally understood by people outside the family. ☐ Yes ☐ No
42. I find myself restating what my child has said to others. ☐ Yes ☐ No

Motor Information

43. My child can **<u>independently:</u>** (check all that apply)
    ☐ Pedal a bike (with or without training wheels) ☐ Pump a swing
    ☐ Walk up or downstairs using one foot per step ☐ Hop on one foot
44. My child has had a **physical therapy evaluation**. ☐ Yes ☐ No
    If YES, did he/she receive therapy? ☐ Yes ☐ No How long? _____
45. My child <u>currently</u> receives **physical therapy.** ☐ Yes ☐ No
    Therapist's name/agency: _____

Sensory Information

46. My child is fearful of loud noises. ☐ Yes ☐ No
47. My child does not like crowds. ☐ Yes ☐ No
48. My child is a picky eater (does not like certain food textures, colors, etc.) ☐ Yes ☐ No
49. My child becomes overwhelmed in new situations. ☐ Yes ☐ No

Childs Name: _____

50. Certain clothing (tags, different materials, etc.) bother my child. ☐ Yes ☐ No
51. My child can hold a crayon to color and draw pictures without difficulty. ☐ Yes ☐ No
52. My child can hold a pencil and write some or all letters of his/her name without difficulty. ☐ Yes ☐ No
53. My child has had an **occupational therapy and/or sensory evaluation.** ☐ Yes ☐ No
    If YES, did he/she receive therapy? ☐ Yes ☐ No How long? _____
54. My child currently receives **occupational therapy.** ☐ Yes ☐ No
    Therapist's name/agency: _____

Attention Information

55. My child gives eye contact to the person speaking. ☐ Yes ☐ No
56. My child is easily distracted. ☐ Yes ☐ No
57. My child sticks to one activity for at least 15 minutes at a time (not including computer or TV) ☐ Yes ☐ No
58. My child darts from one task to another. ☐ Yes ☐ No
59. My child perseverates or excessively over-focuses on things or ideas. ☐ Yes ☐ No
60. My child is overly restless or fidgety. ☐ Yes ☐ No
61. My child has been diagnosed with **ADD** or **ADHD.** ☐ Yes ☐ No

Part 3: Self-Help Information

62. My child can **independently**: (check all that apply)

☐ Put away toys ☐ Hang up coat ☐ Completely get dressed
☐ Clean up a spill ☐ Follow a 2-step direction ☐ Take care of all toileting needs
☐ Button clothing ☐ Put shoes on correct feet ☐ Unscrew jar lids or bottle caps
☐ Zip clothing ☐ Blow or wipe nose without being asked ☐ Ask an adult for help, when needed

Part 4: Social Development Information

63. My child initiates play with other children. ☐ Yes ☐ No
64. My child has opportunities to play with other children his/her own age. ☐ Yes ☐ No
65. My child easily separates from parents. ☐ Yes ☐ No
66. My child is able to take turns. ☐ Yes ☐ No
67. My child gets along well with other children. ☐ Yes ☐ No
68. My child is fearful/anxious and worries a lot. ☐ Yes ☐ No
69. Does your child exhibit any serious behavior problems? (Check those that apply).

☐ Defiance of adults/non-compliant ☐ Tantrums ☐ Use of inappropriate language
☐ Aggressive/violent behavior towards others ☐ Other:_____

70. What is your child's reaction to stress? (Check all that apply)

☐ Cries ☐ Headache ☐ Stomachache ☐ Bites ☐ Other:_____

Discipline

71. Are there challenges with behavior management at home? ☐ Yes ☐ No
    If YES, what is the most effective in establishing acceptable behavior: _____
    _____
    _____

72. My child's **strengths** are:_____
    _____
    _____
    _____

73. There is additional information that I would like to share. ☐ Yes ☐ No
    _____
    _____

Childs Name: _____