**Kindergarten Survey Form**

Child's Name: _____ Address: _____

Date of Birth: _____ Place of Birth: _____

Father's Name: _____ Mother's Name: _____

Home Telephone: _____ Cell Phone: _____

At School, my child should be called:

_____

1. List the names of those who live with the child.
   Parent(s) _____
   Brother(s) and ages _____
   Sister(s) and ages _____
   Other(s) _____

2. Has your child received or is he/she receiving special support or therapy? (Speech, physical or occupational therapy, counseling, other). Please explain:
   _____
   _____
   Has your child received support under Birth to 3 services? (Speech, physical or occupational, other)
   _____
   _____

   Is your child currently receiving support? Yes___ No ___

3. Has your child received any medical attention for the following reason:
   Hearing ____ Allergies ____ Mobility Problems ___
   Diabetes ____Seizures ____ Other ____

4. Has your child attended preschool? If so, what school? For how long?
   _____
   _____

5. Does your child speak a second language? _____
   What is the primary language spoken at home? _____

6. Please check any of the following that your child does INDEPENDENTLY:
   Puts on and takes off mittens ____
   Puts on and takes off jacket/coat/sweater ____
   Puts on and takes off boots ____
   Buttons and unbuttons ____
   Zippers ____
   Ties shoes ____

7. What are your child's strengths? (ie: behavior, academic, self-help)_____
   _____

8. What are your child's needs? (ie: behavior, academic, self-help)_____
   _____

9. What do you hope your child will gain from the kindergarten experience?_____
   _____

10. My child likes to? _____
    _____

11. My child does not like to? _____
    _____