Kindergarten Parent Questionnaire

Welcome to Kindergarten at Renfrew County Catholic District School Board!
We hope that you and your child will enjoy being part of our faith-filled learning community. A child's early years are central to future successes and we are committed to ensuring that your child is given every opportunity to thrive in an atmosphere of warmth, hospitality, good humour, and joy. Information from this questionnaire will serve to support your child's transition to school. Thank you for taking the time to help us to get to know your child.

Student Name:
Date of Birth (Month/Day/Year):
Parent/Guardian Names:
Names of Siblings: **Age:** **Grade:**
With whom does your child live (i.e. mom, dad, mom and dad, grandmother, other)?
In the past twelve months, my child has been cared for in the following ways (*Please check all that apply*): **Full-Time** (more than 24 hours/week) ☐ Care with a parent or relative ☐ Licensed home child care ☐ Child Care Centre or Nursery School ☐ Unlicensed home child care **Part-Time** (less than 24 hours/week) ☐ Care with a parent or relative ☐ Licensed home child care ☐ Child Care Centre or Nursery School ☐ Unlicensed home child care
English is my child's first language. ☐ Yes Languages spoken at home: ☐ No
What time does your child typically go to bed? What time does your child usually wake up? _____ _____

My child can follow a 2-step direction (e.g. please get your bag and put on your shoes)
☐ most of the time ☐ some of the time ☐with adult support

My child is able to tell you what he/she wants and needs
☐ most of the time ☐ some of the time ☐with adult support

My child is able to manage how he/she feels and talk about feelings
☐ most of the time ☐ some of the time ☐with adult support

Are there any situations in which your child becomes particularly excitable, upset, frightened or angry? If yes, please provide examples.
☐ Yes Examples:
☐ No

What comforts your child when he/she becomes upset?

Has your child experienced any significant changes in his/her family life in the past (e.g., death, separation, birth of a baby, family illness, move)? If yes, please provide more information.
☐ Yes Information:
☐ No

My child uses the toilet
☐ Independently ☐With support ☐ Not yet ready

My child dresses (fastens buttons, zips zippers, gets ready for outdoors)
☐ Independently ☐With support ☐ Not yet ready

My child follows routines
☐ Independently ☐With support ☐ Not yet ready

What responsibilities does your child have at home?
☐ Picks up toys ☐ Makes the bed ☐ Helps set the table ☐ Other _____

Has your child been involved in any organized activities? *Please check all that apply.*
☐ Sports ☐ Music ☐ Library Programs ☐ Visits to the Early Years Centre
☐ Community Programs ☐ Other, Please explain

Is there anything else you would like to share about your child (daily routines, likes/dislikes)?

Play Skills

	Not Yet	Sometimes	Often	Almost Always
My child enjoys playing with other children.				
My child is able to join in an activity with other peers.				
My child takes turns and plays cooperatively when playing with other children.				
My child shares when playing with other children.				

Self-Regulation Skills

	Not Yet	Sometimes	Often	Almost Always
My child can tell me what he/she likes or dislikes.				
My child can wait patiently for short periods of time.				
My child can calm down when upset or angry with limited adult assistance.				
My child accepts being told "no" without becoming upset and angry.				
My child can keep his/her hands to himself/herself even when upset or angry.				
My child continues to try when something is difficult.				
My child can easily transition between activities (e.g. play to tidy up time).				

Favourite Activities

How often does your child participate in the following activities?

	Rarely	Sometimes	Very Often
Arts or craft activities (e.g. drawing, gluing)			
Building (e.g. blocks, Lego)			
Imaginative play (e.g. role playing, dress up)			
Playing outside			
Playing video games and computer games			
Playing with other children			
Reading or looking at picture books			
Solitary play			
Watching television or videos			

I have accessed the following supports for my child (*Please check all that apply.)*

□ Medical Professional (e.g. Family Doctor or pediatrician)	□ Behaviour Therapist
□ Speech and Language Therapist	□ Autism Services
□ Occupational Therapist	□ Developmental Services
□ Physiotherapist	□ Ottawa Children's Treatment Centre
□ Psychologist/Psychiatrist	□ CCAC Community Care Access Centre

If any reports were developed, are you willing to share these reports to support your child's transition to school?
□ No □ Yes Please list reports if known:

Does your child have any allergies or take any medication regularly?
□ No □ Yes Please list:

My child has had a recent vision test. □ Yes □ No Date:
My child should wear glasses at school. □ Yes □ No
My child has had a recent hearing test. □ Yes □ No Date:
My child has had middle ear tubes inserted. □ Yes □ No Date:

I have concerns with my child's:

☐ Hearing	☐ Gross motor skills (e.g. running, walking, climbing stairs)	☐ Independence
☐ Vision	☐ Fine motor skills (e.g. picking up small items)	☐ Social interactions with peers
☐ Listening skills	☐ Sensory processing (e.g. dealing with loud noises, wet socks, dirty hands)	☐ Safety (e.g. wandering)
☐ Speaking skills	☐ Attention skills	☐ Other:

☐ I would be interested in learning more about supports that might be available in school and in the community.

Starting school is a new experience for you and your child. Please share with us how you and your child are feeling about this exciting time.
(Please use this section to provide any additional information you feel the school team needs to know to ensure your child has a successful transition to Kindergarten.)

Completed by: _____ Relationship to the Student: _____ Date: _____