



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) _____

Childs Name: _____

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 currently 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 **independently**: (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 currently 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)
- | | | |
|---|--|--|
| <input type="checkbox"/> Put away toys | <input type="checkbox"/> Hang up coat | <input type="checkbox"/> Completely get dressed |
| <input type="checkbox"/> Clean up a spill | <input type="checkbox"/> Follow a 2-step direction | <input type="checkbox"/> Take care of <u>all</u> toileting needs |
| <input type="checkbox"/> Button clothing | <input type="checkbox"/> Put shoes on correct feet | <input type="checkbox"/> Unscrew jar lids or bottle caps |
| <input type="checkbox"/> Zip clothing | <input type="checkbox"/> Blow or wipe nose without being asked | <input type="checkbox"/> 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).
- | | | |
|---|---------------------------------------|--|
| <input type="checkbox"/> Defiance of adults/non-compliant | <input type="checkbox"/> Tantrums | <input type="checkbox"/> Use of inappropriate language |
| <input type="checkbox"/> Aggressive/violent behavior towards others | <input type="checkbox"/> Other: _____ | |
70. What is your child's reaction to stress? (Check all that apply)
- | | | | | |
|--------------------------------|-----------------------------------|--------------------------------------|--------------------------------|---------------------------------------|
| <input type="checkbox"/> Cries | <input type="checkbox"/> Headache | <input type="checkbox"/> Stomachache | <input type="checkbox"/> Bites | <input type="checkbox"/> 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: _____