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Early Childhood Survey

Thank you for taking the time to complete this survey. A copy of the completed survey will be given to your child's teacher to enable him or her to better serve your child.

Child Information

Legal Name: ____________________ (Last) ____________________ (First) ____________________ (Middle)

Preferred Name: ______________ Date of Birth: ________ Sex: ___ Start Date: ____________

Developmental History

1. Does your child dress him/herself? __________
2. Can your child use the bathroom independently? __________
3. Is your child right or left-handed or both? ________________________________

Health History

GENERAL HEALTH

1. What serious illnesses, if any, has your child had?
2. Does your child have any speech problems (e.g. pronouncing words, stuttering, voice quality, etc.)? If yes, what professional help, if any, have you sought?

MEDICAL CONDITIONS

Does your child have any known allergies, asthma, diabetes, or seizures? ❑ Yes ❑ No If yes, please describe, and **you MUST provide an action plan signed by your child's doctor**:

____

____

HEARING & VISION

1. Have you ever thought your child had a hearing problem?

   ____

2. Does your child appear to experience any difficulties with vision? ________________________

SLEEPING HABITS

1. What times does your child go to bed? ______________
2. Does your child experience:
3. nightmares? _______________ sleepwalking? ______________ bed-wetting? ______________

Family Structure

IMMEDIATE FAMILY

1. In comparison to your other children, how does this child relate to siblings and other children?
2. What type(s) of discipline works best for your child?
3. What activities does the family do together?
4. Do you read to your child? ____________ How often? _____________ Is this seen as an enjoyable experience by your child? ______________

EXTENDED FAMILY

1. Is there anyone other than the immediate family living in the home? ________ If yes, who?
2. Are grandparents or other relatives important in your child's life? ____________________

Academics

PRESCHOOL

1. Has your child attended preschool? __________ If yes, where?
2. How did your child react to the experience and what was his or her attitude toward it?

LOOKING AHEAD

1. What is your child's attitude toward coming to school?
2. Do you feel your child will have any difficulty in school?
3. Is there evidence of learning difficulties in other family members (e.g. parents, siblings)?

Personality Characteristics

1. Please describe your child – interests, abilities, likes and dislikes, how he or she gets along with others, how he reacts when frustrated, etc.
2. What are the greatest strengths of your child ?
3. What are some of the challenges that your child is working on?
4. Does your child have any particular fears or anxieties?
5. Are there 2-3 specific areas that you would like to see your child grow in this year?
6. Is there anything you feel the school or the teacher should know about your child that is not included in this form?