

WEST ALLEGHENY SCHOOL DISTRICT
KINDERGARTEN QUESTIONNAIRE

NAME _____ ADDRESS _____
NICKNAME _____
BIRTHDAY _____ PHONE NUMBER _____

_____ RIGHT HANDED _____ LEFT HANDED
_____ No preference shown at this time

Child resides with
_____ both parents _____ father
_____ mother _____ others?
If other, please explain _____
Name of siblings and age _____

Check any of the following which apply to your child.

_____ happy	_____ cooperative
_____ sad	_____ seeks recognition
_____ angry	_____ timid/shy
_____ eager to please	_____ enthusiastic
_____ aggressive	_____ negative
_____ disruptive	_____ negative
_____ easily frustrated	_____ shows self control
_____ overly sensitive	_____ talkative
_____ exhibits sense of humor	_____ distractible

Learning Status

Do you feel your child grasps ideas easily? _____ Yes _____ No
Do you feel your child has a good memory? _____ Yes _____ No
Can your child follow directions? _____ Yes _____ No
Does your child enjoy being read to? _____ Yes _____ No

How often do you read to your child?
_____ daily _____ weekly _____ infrequently _____ never

Does your child prefer to
_____ play alone _____ play with a group of friends?

Does your child relate well to
_____ peers _____ older children _____ younger children?

Is your child able to
_____ share _____ take turns

How much T.V. is your child permitted to watch per day?
_____ unlimited _____ one hour _____ several hours

What T.V. shows does your child enjoy watching on a regular basis?

Does your child have a regular bedtime? _____ Yes _____ No
What time does he/she usually go to bed? _____

What time does he/she awaken in the morning? _____
Does your child take a nap? _____ Yes _____ No
_____ afternoon _____ morning

Does your child have any fears _____ Yes _____ No
Please explain _____

Does your child have allergies? (milk, bees, pollen)
Please explain _____

Does your child take medication? _____ Yes _____ No
Please explain _____

Does your child eat breakfast? _____ Yes _____ No
Does your child snack during the day? _____ Yes _____ No
Did your child attend a preschool program? _____ Yes _____ No
Where did they attend? _____
How many years? _____

Have they received any additional services (DART, Headstart, Speech/Language,
Counseling, on-going medical treatment)? _____ Yes _____ No
Please explain _____

Please explain any significant events that may affect your child. (ex., divorce,
separation, remarriage, death, recent move, illness)

Is there any other information you would like to tell us about your child?

_____ Parent Signature

_____ Date

