



## SCHOOL ENTRY QUESTIONNAIRE

Dear Parent(s)/Guardian(s): Thank you for taking the time to complete this "School Entry Questionnaire" with as much detail as possible. This will allow your child's teacher to get to know your child better and assist in planning the most appropriate program for him/her. Should you need assistance in the completion of this form, please contact the school's principal. Thank you!

— PLEASE FORWARD COMPLETED QUESTIONNAIRE TO THE SCHOOL PRINCIPAL —

Name of Child: \_\_\_\_\_ D.O.B.: \_\_\_\_\_

1. Other children in the family: \_\_\_\_\_ Age: \_\_\_\_\_  
 \_\_\_\_\_ Age: \_\_\_\_\_  
 \_\_\_\_\_ Age: \_\_\_\_\_

2. Others in the household: \_\_\_\_\_ Relationship to the child: \_\_\_\_\_  
 \_\_\_\_\_ Relationship to the child: \_\_\_\_\_

3. What type of child care does your child receive?

- Parent     Nursery School     Daycare Center     Babysitter     Other

### HEALTH INFORMATION

1. Do you have concerns about your child's eating habits (e.g., likes, dislikes)?

- No     Yes \_\_\_\_\_

2. Does your child have any allergies?

- No     Yes \_\_\_\_\_

3. Does your child use the toilet during the day (i.e. toilet trained)?     Yes     No

4. Has your child had:     ear infections? \_\_\_\_\_#     fluid in ears?     tubes? \_\_\_\_\_#

5. Has your child been tested in the following areas:

- \* hearing?     occupational therapy?  
 \* vision?     physiotherapy?  
 speech and language?     pediatric assessment? Name of pediatrician \_\_\_\_\_

What recommendations, if any, were made following these assessments? \_\_\_\_\_

**Note:** It would be beneficial if you could please provide a copy of any assessment reports you've received.

**\* We suggest that you consider having your child's vision and hearing tested before school entry.**

6. Does your child require any medication on a regular basis?

- No     Yes \_\_\_\_\_

7. Does your child have, or has your child had, a serious illness or medical condition?

- No     Yes \_\_\_\_\_

If so, please describe: \_\_\_\_\_

8. Has your child received assistance from any agency during the pre-school years?

- No     Yes \_\_\_\_\_

If yes, please list the agency and describe the assistance: \_\_\_\_\_

9. Does your child sleep well most nights?  Yes  No

10. What is your child's general bedtime routine? \_\_\_\_\_  
\_\_\_\_\_

**SOCIAL AND EMOTIONAL INFORMATION**

1. How would you describe your child's personality (e.g., outgoing, quiet, easy going, nervous, excitable, happy)?  
\_\_\_\_\_

2. Describe your child's choice of playmates (same age, younger, older, adults, alone):  
\_\_\_\_\_

3. Does your child prefer to play:  by him/herself  near other children  with other children

4. Does your child make friends easily?  Often  Seldom  Never

5. Does your child take turns and share with other children?  Often  Seldom  Never

6. Does your child comfort someone who is upset?  Often  Seldom  Never

7. Does your child play near and talk to other children while continuing with own activity?  Often  Seldom  Never

8. Does your child talk with other children when playing?  Often  Seldom  Never

9. Does your child engage in pretend play (e.g. playing house, police officer, etc.)?  Often  Seldom  Never

10. Does your child look for adult approval (eg. "Watch me." or "Look what I did")?  Often  Seldom  Never

11. What kinds of responsibilities does your child have at home (e.g., dressing self, tidying up)?  
\_\_\_\_\_

12. How does your child react to new situations (e.g., shy, fearful, curious, excited)? \_\_\_\_\_  
\_\_\_\_\_

13. How does your child react to being away from Mom or Dad? \_\_\_\_\_  
\_\_\_\_\_

14. How does your child interact with siblings? \_\_\_\_\_  
\_\_\_\_\_

15. Describe any situations in which your child becomes particularly excitable, frustrated, upset, fearful or angry  
(e.g., not getting own way, doing a difficult task): \_\_\_\_\_  
\_\_\_\_\_

16. What techniques have you found to be effective in the situations described above? \_\_\_\_\_  
\_\_\_\_\_

17. Has your child experienced any significant changes in his or her family life in the past  
(e.g., death of a family member, moving, birth of a baby, separation or divorce)? \_\_\_\_\_  
\_\_\_\_\_

18. How do you see your child accepting classroom routines (e.g., waiting turn, cleaning up, sharing with others)?  
\_\_\_\_\_

19. Do you have any concerns about your child's behaviour that you would like to discuss?  
\_\_\_\_\_

## SPEECH / LANGUAGE INFORMATION

1. At what approximate age did your child start talking? \_\_\_\_\_
2. Does your child speak in sentences of a least 4-5 words?  Yes  No
3. Is your child easily understood by people outside the family?  Yes  No
4. Can your child understand three-part related directions and longer sentences (e.g. "Put your toys away and wash your hands before lunch")?  Yes  No
5. Does your child ask a lot of questions?  Often  Seldom  Never
6. Does your child enjoy: listening to stories?  Yes  No  
looking at books?  Yes  No
7. Do you read to your child daily?  Yes  No
8. Does your child ask questions, make comments or talk about the pictures in a book?  Yes  No
9. Can your child tell what is happening in a picture when asked?  Yes  No
10. Does your child use word endings as in **running** and **jumped**?  Often  Seldom  Never
11. Does your child like to: sing?  Yes  No  
recite nursery rhymes?  Yes  No  
do actions to songs?  Yes  No
12. What primary language is spoken in the home? \_\_\_\_\_
13. What additional languages are spoken in the home? \_\_\_\_\_

## FINE & GROSS MOTOR SKILLS

1. Does your child hold a crayon or pencil correctly?  Yes  No
2. Can your child print his/her name?  Yes  No
3. Can your child undo: buttons?  Yes  No  
zippers?  Yes  No  
shoes?  Yes  No
4. Can your child dress himself/herself?  Yes  No
5. Has your child had experience with: drawing, colouring, painting?  Yes  No  
using plasticine, play dough?  Yes  No  
using scissors?  Yes  No
6. At approximately what age did your child: walk? \_\_\_\_\_  
Catch a ball? \_\_\_\_\_  
Climb stairs? \_\_\_\_\_

**SCHOOL READINESS SKILLS**

- 1. Does your child recognize any letters of the alphabet ?  Few  Some  Most
- 2. Does your child make any letter sounds?  Few  Some  Most
- 3. Does your child recognize numbers to 10?  Few  Some  Most
- 4. Does your child recognize shapes?  Few  Some  Most
- 5. Does your child recognize sizes? (Eg. Big, small, etc.)  Few  Some  Most
- 6. Does your child recognize colours?  Few  Some  Most
- 7. Does your child play with puzzles?  Yes  No
- 8. Has your child had any experience with computers?:  Yes  No

9. What types of activities does your child enjoy:

- Active/physical: Describe \_\_\_\_\_
- Arts/crafts: Describe \_\_\_\_\_
- Toys: Describe \_\_\_\_\_
- TV/Videos: Describe \_\_\_\_\_
- Participation in Parish Activities: Describe \_\_\_\_\_
- Other: Describe \_\_\_\_\_

- 10. Do you feel that your child will be able to pay attention during a teacher-directed group activity (e.g., Circle Time)?  Yes  No
- 11. Can your child sit quietly when listening in circle time, at church or when listening to stories?  Yes  No  Don't know
- 12. Does your child listen to and willingly follow adult requests?  Often  Seldom  Never
- 13. Is your child looking forward to school?  Yes  No If not, please elaborate: \_\_\_\_\_

14. The Kindergarten years are a time of tremendous growth for young children - a time in which they grow physically, socially, emotionally, spiritually, and intellectually.

During these years your child will learn to:

- ❖ celebrate the many gifts that God has given to us in creation, in ourselves, and in each other;
- ❖ work alone and with others;
- ❖ explore and expand his/her abilities and interests;
- ❖ listen to and share with others;
- ❖ begin simple problem-solving;
- ❖ develop responsibility for selecting and caring for materials;
- ❖ express his/her thoughts and ideas.

Please list any additional expectations you may have of the Kindergarten program? \_\_\_\_\_

Additional Comments: \_\_\_\_\_

**Thank you for taking the time to complete this questionnaire. Please forward to the School Principal.**

**Information Collection Authorization:** This information is collected pursuant to the Board's education responsibilities as set out in the Education Act and its regulations. The information is collected for education purposes and is within guidelines set out in the Municipal Freedom of Information and Protection of Privacy Act, 1989. This information will become part of the Ontario Student Record and Student Services file. Any questions with respect to this information should be directed to the Principal of the School to which you are applying/registered. Users: Supervisory Officers, Principals, Teachers and Student Services staff.

**Copies to:** 1. Ontario Student Record (OSR) 2. Classroom Teacher 3. Parent(s)/Guardian(s) (upon request)