Fountain • Fort Carson
SCHOOL DISTRICT EIGHT

FOUNTAIN-FT. CARSON SCHOOL DISTRICT 8

KINDERGARTEN QUESTIONNAIRE

Please note that any out-of-district requests may require follow-up from administration.

PLEASE PRINT

Child: _____ Date of Birth: _____ Gender: M / F
First Name Middle Name Last Name

Address: _____ City: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Child's Primary Language: _____

Medical History:

Has your child had any of the following (check all that apply)?

_____Upper Respiratory Infections	_____Bone/Orthopedic Problems	_____Sleeping Problems
_____Allergies	_____Head Injuries/Unconsciousness	_____Dental Problems
_____Frequent Ear Infections	_____Convulsions/Seizures	_____High Fever
_____Feeding/Eating Tubes	_____Weight Problems	_____Frequent Sore Throat
_____Stomachaches	_____Bladder/Kidney Problems	_____Asthma
_____Heart Problem/Condition	_____Emotional Problems	_____Frequent Nose Bleeds
_____Surgery	_____Significant Accident/Injury	_____Anemia

Please explain any of the above: _____

_____

How is your child's health now? Excellent / Good / Fair / Poor

Explain any health concerns: _____

_____

Does your child have a known medical diagnosis? YES / NO If yes, what is the diagnosis? _____

Is your child taking any medication? YES / NO Please list: _____

Are your child's shots up to date? YES / NO

Does your child have any food allergies? YES / NO Please explain: _____

Developmental Information:

(In the following areas, please check whether your child was early, average or late in developing)

	Early	Average	Late		Early	Average	Late
Turned Over				Walked Alone			
Smiled at Parents				Fed Self			
Sat alone				Said "no,no" to everything			
Crawled				Used Sentences			
Said First Word				Stayed Dry During Day			
Helped with Dressing				Stayed Dry During Night			
Drank from a Cup				Dressed Alone			
Concerns noted by your child's pediatrician:							

Social History and Functioning:

Does your child currently attend a preschool or childcare? YES / NO If yes, where? _____

Describe your child's relationship with caregivers: _____

Describe how your child separates from caregivers: _____

Describe your child's relationship with siblings: _____

Describe your child's strengths: _____

What worries you about your child's social functioning? _____

What does your child enjoy? _____

What bothers your child? _____

Do you have questions or concerns about your child's behavior? YES / NO Please explain: _____

_____

Identify the behaviors below that your child displays that you believe are atypical: (check any that apply)

☐ Impulsive	☐ Distractible	☐ Prefers to Play Alone	☐ Rocks	☐ Shy or Timid
☐ Has Temper Tantrums	☐ Starts Fires	☐ Show Dare-Devil Behavior	☐ Stubborn	☐ Clumsy
☐ Doesn't Pay Attention	☐ Easily Frustrated	☐ Daydreams	☐ Moody	☐ Falls a lot
☐ Avoids Attention	☐ Dislikes Changes	☐ Hits Caregivers	☐ Has Fears	☐ Holds Breath
☐ Cruel to Animals	☐ Bangs Head	☐ Is Aggressive to others		

Additional Information: _____

_____

Relevant Family Information:

What major changes have occurred in your family or child's life over the last year? _____

_____

How many times has your family moved in the last year? _____

What activities does your family like to do together? _____

_____

Relatives or other individuals who are available to support your family: _____

_____

I AM THE LEGAL GUARDIAN OF THIS CHILD AND CERTIFY THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE.

Signature: _____ Date: _____

Reviewer Signature: _____ Date: _____