



# FOUNTAIN-FT. CARSON SCHOOL DISTRICT 8

## KINDERGARTEN QUESTIONNAIRE

Fountain • Fort Carson  
SCHOOL DISTRICT EIGHT

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)?

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Upper Respiratory Infections | <input type="checkbox"/> Bone/Orthopedic Problems      | <input type="checkbox"/> Sleeping Problems    |
| <input type="checkbox"/> Allergies                    | <input type="checkbox"/> Head Injuries/Unconsciousness | <input type="checkbox"/> Dental Problems      |
| <input type="checkbox"/> Frequent Ear Infections      | <input type="checkbox"/> Convulsions/Seizures          | <input type="checkbox"/> High Fever           |
| <input type="checkbox"/> Feeding/Eating Tubes         | <input type="checkbox"/> Weight Problems               | <input type="checkbox"/> Frequent Sore Throat |
| <input type="checkbox"/> Stomachaches                 | <input type="checkbox"/> Bladder/Kidney Problems       | <input type="checkbox"/> Asthma               |
| <input type="checkbox"/> Heart Problem/Condition      | <input type="checkbox"/> Emotional Problems            | <input type="checkbox"/> Frequent Nose Bleeds |
| <input type="checkbox"/> Surgery                      | <input type="checkbox"/> Significant Accident/Injury   | <input type="checkbox"/> 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)

- |  |  |   |                                    |                                       |
|--|--|---|------------------------------------|---------------------------------------|
| <input type="checkbox"/> Impulsive             | <input type="checkbox"/> Distractible      | <input type="checkbox"/> Prefers to Play Alone    | <input type="checkbox"/> Rocks     | <input type="checkbox"/> Shy or Timid |
| <input type="checkbox"/> Has Temper Tantrums   | <input type="checkbox"/> Starts Fires      | <input type="checkbox"/> Show Dare-Devil Behavior | <input type="checkbox"/> Stubborn  | <input type="checkbox"/> Clumsy       |
| <input type="checkbox"/> Doesn't Pay Attention | <input type="checkbox"/> Easily Frustrated | <input type="checkbox"/> Daydreams                | <input type="checkbox"/> Moody     | <input type="checkbox"/> Falls a lot  |
| <input type="checkbox"/> Avoids Attention      | <input type="checkbox"/> Dislikes Changes  | <input type="checkbox"/> Hits Caregivers          | <input type="checkbox"/> Has Fears | <input type="checkbox"/> Holds Breath |
| <input type="checkbox"/> Cruel to Animals      | <input type="checkbox"/> Bangs Head        | <input type="checkbox"/> 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: \_\_\_\_\_