

Kindergarten Entry Questionnaire

Student Name: _____ OEN _____

Date of Birth: _____ School: _____

We would like to ask you some questions about your child. This questionnaire is an important step in developing a positive working relationship between home and school.

1. My child attended Nursery School, Preschool or Day Care. Length of time _____.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
2. My child dresses and undresses with little help.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
3. My child can undo most buttons.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
4. My child is completely toilet trained.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
5. My child speaks English at home. Other languages spoken at home: _____	Yes <input type="checkbox"/>	No <input type="checkbox"/>
6. My child can follow simple directions with 2 or 3 steps (e.g., brush your teeth and get your pajamas).	Yes <input type="checkbox"/>	No <input type="checkbox"/>
7. My child usually does what he or she is told.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
8. My child's speech can usually be understood by people outside the family.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
9. My child asks lots of questions.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
10. My child can tell me what is happening in a picture.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
11. My child uses sentences.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
12. My child uses endings on words (e.g., looked , balloons , eating).	Yes <input type="checkbox"/>	No <input type="checkbox"/>
13. My child can continue an activity for a while.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
14. My child can play a pretend game alone for 15- 20 minutes.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
15. My child is very active.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
16. My child takes turns and shares with other children in small group activities.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
17. My child tries to comfort or help someone who is upset.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
18. My child goes up and down the stairs putting one foot on each step (not both feet on each step).	Yes <input type="checkbox"/>	No <input type="checkbox"/>
19. My child can stand on one foot for one to three seconds without support.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
20. My child can catch a large ball.	Yes <input type="checkbox"/>	No <input type="checkbox"/>

21. My child plays active games daily (e.g. biking, jumping, swimming, running)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
22. My child watches T.V. If yes, average amount of T.V. watched daily: _____	Yes <input type="checkbox"/>	No <input type="checkbox"/>
23. My child has had experiences with colouring and craft materials (e.g., glue, scissors, paint, playdough, crayons, and markers).	Yes <input type="checkbox"/>	No <input type="checkbox"/>
24. My child can print his or her first name.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
25. My child can snip paper with scissors.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
26. My child repeats nursery rhymes and children's songs.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
27. My child likes books.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
28. My child and I read together on a daily basis.	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Please check if your child has done any of these things:	
<input type="checkbox"/> played organized sports (e.g., T-ball, soccer, hockey, karate)	<input type="checkbox"/> participated in programs through organizations like parks and recreation or the YMCA
<input type="checkbox"/> taken music, drama or dance lessons	<input type="checkbox"/> gone to library story times
<input type="checkbox"/> gone to religious school	<input type="checkbox"/> used the Early Years Centre

ADDITIONAL HEALTH INFORMATION

1. My child has had his/her hearing tested. Follow up action if needed? _____	Yes <input type="checkbox"/>	No <input type="checkbox"/>
2. My child has had his/her vision tested. Follow up action if needed? _____	Yes <input type="checkbox"/>	No <input type="checkbox"/>
3. My child has had a speech and language assessment. Follow up action if needed? _____	Yes <input type="checkbox"/>	No <input type="checkbox"/>
4. My child has medical or health concerns of which the school should be aware. Please specify: _____	Yes <input type="checkbox"/>	No <input type="checkbox"/>
5. My child takes medication on a regular basis. Medication(s): _____	Yes <input type="checkbox"/>	No <input type="checkbox"/>
6. My child will need to have oral medication administered at school.	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Some children have received support and/or assistance from organizations in the community. Please indicate if your child or family have used the services of any of the following agencies:

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| <ul style="list-style-type: none"> <input type="checkbox"/> Association for Community Living <input type="checkbox"/> Infant Development Program <input type="checkbox"/> Behaviour Management Services of Simcoe and York <input type="checkbox"/> Preschool Resource Teacher/Early Interventionist <input type="checkbox"/> Geneva Centre <input type="checkbox"/> Kerry's Place <input type="checkbox"/> Bloorview MacMillan Centre <input type="checkbox"/> Community Care Access Centre (CCAC) <ul style="list-style-type: none"> <input type="checkbox"/> Occupational therapy <input type="checkbox"/> Physiotherapy <input type="checkbox"/> Speech and language pathology <input type="checkbox"/> Nursing <input type="checkbox"/> Dietitian | <ul style="list-style-type: none"> <input type="checkbox"/> Kinark Child and Family Services <input type="checkbox"/> Catulpa Tamarac Child and Family Services <input type="checkbox"/> New Path Youth and Family Counseling Services <input type="checkbox"/> Seasons Centre for Grieving/Traumatized Children <input type="checkbox"/> Children's rehabilitation/therapy service <ul style="list-style-type: none"> <input type="checkbox"/> Occupational therapy <input type="checkbox"/> Physiotherapy <input type="checkbox"/> Feeding and swallowing clinic <input type="checkbox"/> Simcoe County preschool speech and language program <input type="checkbox"/> Hearing and audiology services <input type="checkbox"/> Psychology |
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- Hospital for Sick Children
- Children's Aid Society
- Huronia Hearing Impaired
- Ernest C. Drury School for the Deaf
- Canadian National Institute for the Blind
- Ontario Foundation for the Visually Impaired
- Public Health Nursing
 - Healthy Babies, Healthy Children
 - Children in Need of Treatment Dental Program (CINOT)

Resources from other communities:

- Speech and Language Services
- Early Intervention Program
- Infant Development Program
- Therapeutic Services (e.g., Occupational Therapy, Physical Therapy)
- Other: _____
- Barrie & District Association for People with Special Needs

Parent/Guardian

Signature: _____

Date: _____

The personal information that you provide is collected under the authority of section 265(j) and 265(d) of the Education Act (RSO 1990). It will be used to assist in providing an appropriate program of instruction for your child. A copy of the completed form will be placed in the Ontario Student Record. Any questions regarding this collection information should be directed to the Principal.

Distribution: OSR ✓