Is there any other information regarding your child's development that you would like to share with us?

Signature of Parent/Guardian _____ Date _____

2018 / 2019

PRIMARY PARENT QUESTIONNAIRE

Puddletown School

Your responses on this questionnaire will help us to learn more about your child. Please complete each item and return it with your completed application form. There are no "right" or "wrong" answers to the questions. Please add longer responses to a separate piece of paper

Child's Name: _____ Date of Birth _____

What languages are spoken in the home? _____

PLEASE TELL US ABOUT YOUR CHILD.

1. Describe a typical weekday for your child.

2. Describe a typical weekend for your child.

3. What are two things that your child likes to do best?

4. What are two things your child does not like to do?

5. What is your favorite thing to do with your child?

6. What are three words you feel best describe your child?

7. What do you enjoy most about your child? What makes him/her special?

TELL US ABOUT YOUR CHILD'S DAY.

1. What is your child's normal naptime? _____ bedtime? _____

   How long does he/she normally sleep? _____

   Where does he/she usually fall asleep? (in his/her bed, in your bed, in your arms, on the sofa...)

   _____

2. What time does your child normally wake up in the morning?_____

3. How does your child respond to accidents? (something breaking, an unexpected event)

   _____

4. What does your child normally eat for breakfast?

   _____

5. What does your child like to eat most?

   _____

6. Are there any foods that he/she will not eat?

   _____

7. Does your child feed him/herself using a spoon and/or fork?

   _____

8. Does your child dress him/herself?

   _____

9. What are your child's responsibilities at home? (putting things away, set table etc.)

   _____

10. Does your child use the toilet independently? If not, please tell us where she/he is in this process.

    _____

11. Please tell us about your approach to discipline? (time-out, spanking, redirecting...)

    _____

    _____

MEDICAL HISTORY

1. Were there any significant problems during pregnancy or directly following birth that might have an effect on your child's development (ie. Premature birth, low birth weight, etc)?

   _____

2. Have you ever suspected that your child has vision problems? ❒ Yes ❒ No

   If yes, please explain:_____

3. Have you ever suspected that your child has hearing problems? ❒ Yes ❒ No

   If yes, please explain:_____

4. Has your child ever had trouble walking, climbing, reaching, holding on to things? ❒ Yes ❒ No

   If yes, please explain:_____

5. Does your child have food allergies? ❒ Yes ❒ No

   If yes, please describe:_____

6. Is your child presently on any medications? ❒ Yes ❒ No

   If yes, please describe:_____

DOES YOUR CHILD:

Have older or younger siblings?_____

Speak so that he or she can be understood by others? ❒ Yes ❒ No _____

Express his or her thoughts and needs easily? ❒ Yes ❒ No_____

Use crayons and/or markers to scribble or draw? ❒ Yes ❒ No _____

Listen to stories being read? ❒ Yes ❒ No _____

Recall and retell stories or events? ❒ Yes ❒ No_____

Have media time? How much and what type? _____

Talk with your friends/relatives who come to visit? ❒ Yes ❒ No_____

Follow simple, age-appropriate directions? ❒ Yes ❒ No _____

Have opportunity to play with other children? ❒ Yes ❒ No _____