

Mother Seton School
100 Creamery Road
Emmitsburg, MD 21727

PARENT SURVEY
for Students Entering PreK and Kindergarten

Please answer the questions on this form to the best of your knowledge. Your responses will be shared with school personnel to assist in planning an educational program for your child.

Child's Full Name _____

Date of Birth _____ Place in family _____

Pre-school (if attended) _____

Telephone _____

Months/years attended _____ Days/hours per week attended _____

Current teachers name _____

Describe your child in 4 or 5 words:

General Health History

Please check any health concern that you or your doctor have observed:

- | | | |
|--|--|---|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Loss of consciousness |
| <input type="checkbox"/> Indigestion | <input type="checkbox"/> Allergies | <input type="checkbox"/> Chronic Ear (more than 2 per year) |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Serious blows to head | <input type="checkbox"/> Overtired or lacking pep |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Headaches | <input type="checkbox"/> Nose bleeding |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Nightmares | <input type="checkbox"/> Heart Trouble |
| <input type="checkbox"/> Stomachaches | <input type="checkbox"/> Thumb sucking | <input type="checkbox"/> Hyperactivity |
| <input type="checkbox"/> Frequent fevers | <input type="checkbox"/> Nail Biting | <input type="checkbox"/> Medical Problems |
| <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Epilepsy(seizures) | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Diabetes | | |
| <input type="checkbox"/> Other health concerns (explain) | | |

Is this child on medication for a chronic condition? Yes No
If yes, explain.

Has your child had any significant injuries or hospitalization? Yes No
If yes, please explain

Is your child "healthy" on this day of screening? Yes No
If no, please explain

Hearing – Listening

Does your child:
Seem to have good hearing? Yes No
If no, explain

Does your child: (Yes) (No)
Enjoy reciting simple poems & rhymes? _____ _____

Frequently need directions repeated? _____
Like to be read to? _____
Frequently interrupt when being spoken to? _____
Has your child ever had any ear/hearing examination or treatment? _____
If yes, explain _____

Has your child been diagnosed for a particular hearing difficulty? _____
If yes please explain _____

Language Development

At what age did your child first begin to speak? Give approximate age if you do not remember exact age:

First words _____ Two or three words together _____

Sentences _____

Does your child:	Yes	No
Seem to speak appropriately for age?	_____	_____
Have difficulty expressing ideas and concepts?	_____	_____
Have difficulty articulating certain sounds?	_____	_____

If yes, please indicate which sounds

Visual Assessment

	(Yes)	(No)
Do you suspect any vision problem?	_____	_____
If yes, explain		

Does your child:		
Wear glasses?	_____	_____
Has your child ever had a vision examination or treatment?	_____	_____
If yes explain		

Motor Development

This child began walking at age (if guess, label as such) _____

Do you feel your child has adequate large muscle coordination? Yes No
(run, jump, throw, catch)
If no explain

Do you feel your child has appropriate small muscle coordination for age? Yes No
(hold spoon, fork, dress, hold crayons)
If no explain

Does your child enjoy physical activity? Yes No

Additional Comments:

Social Development

Does your child:	Yes	No
Have regular playmates the same age?	_____	_____
Prefer to play with older or younger children?	_____	_____
Prefer to play with other children instead of alone?	_____	_____
Cry often?	_____	_____
Enjoy group activities?	_____	_____
Become frequently irritated or moody?	_____	_____
Become upset by changes in routine?	_____	_____
Demand much individual adult attention?	_____	_____

What losses has your child experienced?

How does your child deal with these losses?

What kinds of things typically frustrate your child?

How does your child handle these frustrations?

How does your child adjust to new situations and people?

What kinds of limit setting/discipline work best with your child?

Is there any other information that will help us understand this child?

Home Information

Names of adults in the home who are responsible for upbringing and education of child and relationship to child

Has child had other caretakers? If yes at what age, for how long, relationship to child.

Person completing form

Telephone

Relationship to Child