HULL PUBLIC SCHOOLS
PRESCHOOL PARENT QUESTIONNAIRE FORM

Dear Parent:

Please take 10 minutes of your time to answer the questions on this form in the best way that you can. You will be able to answer some quite easily, and may have difficulty in making a decision on others.

Your answers on this form will help the preschool staff decide what kind of educational program is best suited for your child.

This questionnaire is confidential and your responses will be shared only with professional personnel.

Date: _____

Child's Name: _____
First Middle Last

Address: _____

Sex: ☐ F ☐ M ☐ Non-binary D.O.B.: _____ Place of Birth: _____

Telephone #: Home: _____ Work: _____

Email: _____

Name if Person(s) Filling Out Form: _____ Relationship To Child: _____

1. <u>Child's History</u>:

a. Has child attended school before? ☐ Yes ☐ No

b. If Yes, name of school _____

Dates of attendance (month/year) _____

Number of days per week: ☐ 2 ☐ 3 ☐ 4 ☐ 5

c. Any other school experience? _____

2. <u>Child's Status in Family:</u>

a. ☐ oldest ☐ middle ☐ youngest ☐ only

b. Other children in the family:

_____ Age _____ _____ Age _____

_____ Age _____ _____ Age _____

_____ Age _____ _____ Age _____

c. Do any of your children have difficulty in school/daycare:

Name	School	Difficulty
_____	_____	_____
_____	_____	_____
_____	_____	_____

d. Has any family member or close relative had significant difficulty in school?

If yes, Relationship: _____ Nature of Difficulty: _____

3. Parents/Guardians:

a. ☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Widowed

b. Parent/Guardian Name: _____ Occupation: _____

Place of Work: _____

c. Parent/Guardian Name: _____ Occupation: _____

Place of Work: _____

d. Highest grade completed: (circle)

Parent/Guardian: 8 or less 9 10 11 12 College: 1 2 3 4 more

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e. Other persons residing in the household:

Name (s): _____

Relationship (s): _____

f. Have there been any extraordinary events in this household? (e.g. illness, moves, death, disaster, change in make-up of family)

_____

_____

g. Any serious family health problems? _____

4. Basic Medical Data:

a. Name of child's doctor: _____ Tele. #: _____

Address: _____

b. Name of child's dentist: _____ Tele. #: _____

Address: _____

c. Has this child ever had any ear/hearing examination or treatment?
☐ Yes ☐ No If Yes: ☐ Infrequent (2-3 times per year)
☐ Frequent (4 or more a year) ☐ Prolonged (10 days – 2 weeks)
Has your child had tubes inserted? ☐ Yes ☐ No
Date (s) _____
Do you suspect any hearing problem? ☐ Yes ☐ No

Does this child:

1. Seem to have difficulty hearing? ☐ Yes ☐ No
2. Turn up the TV louder than other member of family? ☐ Yes ☐ No
3. Seem to favor one ear over the other? ☐ Yes ☐ No
4. Jump or appear to be more startled than others if there is sudden noise? ☐ Yes ☐ No
5. Seem to hear you if you talk in a whisper? ☐ Yes ☐ No
6. Make you talk loudly or repeat frequently? ☐ Yes ☐ No

e. Has this child ever had a vision examination or treatment? ☐ Yes ☐ No

If so, when _____ who _____
Results _____

Do you suspect any vision problems? ☐ Yes ☐ No

Does this child:

1. Seem to have difficulty seeing small lines or pictures? ☐ Yes ☐ No
2. Seem to have a problem seeing things far away? ☐ Yes ☐ No
3. Squint? ☐ Yes ☐ No
4. Wear glasses? ☐ Yes ☐ No
5. Have eyes that turn in? ☐ Yes ☐ No
6. Sit very close to television? ☐ Yes ☐ No
7. Rub eyes frequently? ☐ Yes ☐ No

f. At what age did this child first begin to speak? Give approximate age if you do not remember exact age: _____

Age of first words _____ Age of two or three words together _____

Age of first Sentence _____Does this child stutter? ☐ Yes ☐ No

g. At what age did this child begin walking? (give approximate age if you do not remember, label as such) _____

Do you feel your child has adequate large muscle coordination? ☐ Yes ☐ No

h. Do you notice, or has a doctor reported, any of the following in this child? If yes, use (x).

___ Asthma	___ Nose Bleeding	___Frequent Fevers
___ Constipation	___ Bed Wetting	___Epilepsy (seizures
___ Diarrhea	___ Bed Soiling	___ Overtired/Lacking Pep
___ Vomiting	___ Diabetes	___ Serious blows to head
___ Headaches	___ Thumb Sucking	___ Lack of Consciousness
___ Nail Biting	___ Chronic Ear Infections	
___ Sinus Trouble	___ Chronic Stomach Problems	
___ Heart Trouble	___ Medical Problems Immediately After Birth	
___ Hyperactivity	___ Allergies (types) _____	

5. <u>Please check (x) Yes, Sometimes, No, or Not sure for each of the following statements</u>:

a. It is my (our) opinion that this child:

	YES	SOMETIME	NO	NOT SURE
Should have regular playmates the same age				
Has difficulty getting along with other children				
Prefers to play with other children instead of alone				
Is difficult to understand when talking				
Seems generally happy				
Is frequently irritable or moody				
Is upset by changes in routine				
Demands much individual adult attention				
Accepts discipline and limits				
Becomes confused in following more than two Verbal directions at a time				
Has difficulty remembering things for a short time				
Has difficulty remembering things for a long time				
Is easily frustrated				
Cries easily				
Cooperates willingly				
Has a bad temper				
Can use a fork and spoon without help				
Can catch a ball thrown to him				
Enjoys physical activities				
Loses balance, trips and falls				
Is dealing with family stress such as illness, death? or separation				

b. How old are this child's playmates? _____

c. About how many hours a day does your child watch TV? _____

d. What kinds of things do you like to do with your child? _____

_____

_____

e. Do you have any special concerns about this child? _____

_____

_____

f. Is your child toilet trained? _____

g. Is there any other information that will help us better understand this child? _____
_____
_____

h. Other physical problems or serious illnesses? (explain) _____
_____
_____

i. Child's birth weights _____ lbs. _____ ozs.

j. Special Considerations:

☐ Caesarean	☐ Child Rotated	☐ Premature
☐ Cord Around Neck	☐ Breech	☐ Twin (1st/2nd born)
☐ Baby Blue	☐ Baby Yellow	☐ Baby Bruised
☐ R.H. Negative	☐ Transfused	

k. Special Care:

☐ Oxygen (how long) _____
☐ Incubator, (how long)_____
☐ Hospital Stay (how long)_____
☐ Seizures or loss of consciousness?_____
☐ Is this child presently on medication? If so, what? _____

l. Has child had any significant injuries or hospitalization? _____
_____
_____

m. Is this child prone to certain ailments? (e.g. ear infections, stomach aches, etc?)_____
_____
_____

n. Has your child ever been referred for Special Education needs…. Past or present? ___
_____
_____

6. Do you participate in any of the following programs (Please check)?

☐ Social Security ☐ Medicaid ☐ Welfare

☐ Aid for Dependent Children (AFDC)

Thank you for your cooperation in filling out this questionnaire.

***** Students who are turning four years old are eligible for the full day program.**

☐ Yes, I would like my child to be considered for the full day program.

☐ No, I would not like my child to be considered for the full day program.

Name: _____

Date: _____