Early Childhood Parent Questionnaire

Child’s Name: ____________________________________________

What language is spoken in the home?  □ English  □ Other (specify) _____________

<table>
<thead>
<tr>
<th>Pre-School / Child Care History</th>
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<tbody>
<tr>
<td>Has your child attended preschool/child care before? □ Yes □ No</td>
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<tr>
<td>If yes, for how long? □ 6 months □ 2 years □ more than 2 years</td>
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Name of your child’s present or most recent school ______________________________

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<tr>
<th>Medical History</th>
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<tr>
<td>Were there any significant problems during pregnancy or directly following birth that might have an effect on your child’s development (i.e. Premature birth, low birth weight, etc)?</td>
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Was your child more than 3 weeks premature? □ Yes □ No

Have you ever suspected that your child has vision problems? □ Yes □ No
   If yes, please explain:
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________

Have you ever suspected that your child has hearing problems? □ Yes □ No
   If yes, please explain:
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
Has your child ever had trouble walking, climbing, reaching, holding on to things? □ Yes □ No
If yes, please explain:

_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________

Medical History - continued

Does your child have allergies? □ Yes □ No
If yes, please describe:

_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________

Is your child presently on any medications? □ Yes □ No
If yes, please describe:

_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________

Child’s Development

Can your child: feed him or herself using a spoon and/or a fork? □ Yes □ No
Speak so that he or she can be understood by others? □ Yes □ No
Express his or her thoughts and needs easily? □ Yes □ No

Is your child: in need of help with toileting? □ Yes □ No
toilet trained during the day? □ Yes □ No

If checking ‘No’ for the above question, your child MUST be toilet trained by the day school starts.

Does your child: use crayons and/or markers to scribble or draw? □ Yes □ No
listen to stories being read? □ Yes □ No
recall stories or events? □ Yes □ No
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

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

_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________

Signature of Parent/Guardian_______________________ Date ______________