2017-2018

IBERIA PARISH KINDERGARTEN INFORMATION SHEET

Child's Information:

Name: *(first)* _____ *(middle)* _____ *(last)* _____

Sex: ☐ Male ☐ Female Date of Birth: _____ Social Security Number: _____

Race: ☐ American Indian ☐ Asian ☐ Black ☐ Hispanic ☐ White ☐ Other: _____

Father's Information:

Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home #: _____ Cell #: _____ Work #: _____

Educational Background: ☐ Grade School ☐ High School ☐ College Occupation: _____

Mother's Information:

Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home #: _____ Cell #: _____ Work #: _____

Educational Background: ☐ Grade School ☐ High School ☐ College Occupation: _____

Child lives with: (name)_____ (relationship)_____

Position of Child in Family: _____

List Other Children in Family: *(name)* _____ *(age)* _____ *(grade)* _____

(name) _____ *(age)* _____ *(grade)* _____

(name) _____ *(age)* _____ *(grade)* _____

(name) _____ *(age)* _____ *(grade)* _____

Is a second language spoken in the home? ☐ Yes ☐ No If yes, which language? _____

In case of emergency, call: *(name)*_____ *(phone #)* _____

*(name)*_____ *(phone #)* _____

Educational Information: (√ or fill in appropriate answer)

Did your child attend a Public School Pre-K Class?	☐ Yes ☐ No
Did your child attend Head Start?	☐ Yes ☐ No
Has she/he attended a nursery school or private kindergarten?	☐ Yes ☐ No
Has your child received help from any agency prior to beginning school? **(guidance center, mental health clinic, etc.)**	☐ Yes ☐ No

If yes, which agency? _____

Other Information: (√ or fill in appropriate answer)

Child Sleeps: ☐ In own room ☐ With one other ☐ With more

Child goes to bed at _____ o'clock. Child gets up at _____ o'clock.

Child takes an afternoon nap?	☐ Yes	☐ No	
Child's Appetite:	☐ Good	☐ Poor	
Is your child toilet trained?	☐ Yes	☐ No	
Is your child a chronic bed wetter?	☐ Yes	☐ No	
Which hand does your child use most often?	☐ Right	☐ Left	☐ Both

(CONTINUE ON BACK)

Medical Information: *(√ and/or fill in appropriate answer)*

Does your child have allergies? ☐ Yes ☐ No
If yes, list: _____
Is your child presently under a physician's care? ☐ Yes ☐ No
If yes, describe: _____
Does your child take any medication? ☐ Yes ☐ No
If yes, describe: _____
Does your child have any physical handicap? ☐ Yes ☐ No
If yes, describe: _____
Do you think your child might have a hearing problem? ☐ Yes ☐ No
If yes, describe:
Has your child ever been under the care of a doctor/ear specialist for his ears? ☐ Yes ☐ No
If yes, which doctor? _____ When? _____
If yes, describe: _____
Do you think your child might have vision problem? ☐ Yes ☐ No
If yes, describe: _____
Has your child ever been under the care of an eye doctor for his eyes? ☐ Yes ☐ No
If yes, which doctor? _____ When? _____
If yes, describe: _____
Have your child's eyes been checked by an eye doctor in the last 6 to 12 months? ☐ Yes ☐ No
Does your child stutter? ☐ Yes ☐ No ☐ Sometimes
Do you feel your child has difficulty saying words? ☐ Yes ☐ No ☐ Sometimes
Do other people have trouble understanding your child when she/he talks? ☐ Yes ☐ No
Does your child have difficulty understanding what you say to him? ☐ Yes ☐ No
Does your child have a hoarse or deep voice? ☐ Yes ☐ No
Does your child often "lose his/her voice? ☐ Yes ☐ No
Has your child ever been examined by a throat specialist? ☐ Yes ☐ No
Does your child have vocal nodules or polyps? ☐ Yes ☐ No
Has your child ever been evaluated for a speech problem, hearing problem, etc. by UL, the school system or any agency? ☐ Yes ☐ No
If yes, where? _____
Has your child ever received speech therapy? ☐ Yes ☐ No
If yes, where? _____

Child's Major Interests: *(√ all that apply)*

☐ Listening to radio
☐ Going to movies
☐ Collecting things
☐ Taking care of pet
☐ Looking at books/magazine
☐ Drawing or coloring pictures
☐ Building or making things
☐ Watching television
☐ Listening to music
☐ Playing by himself
☐ Playing with others
☐ Telling stories

Child's Characteristics: *(based on your observations, √ any of the following that best describes your child)*

☐ Patient
☐ Healthy
☐ Shy
☐ Aggressive
☐ Active
☐ Selfish
☐ Imaginative
☐ Easily upset
☐ Easily injured
☐ Can go to bathroom alone
☐ Can dress himself
☐ Excited about attending school
☐ Dreads going to school
☐ Gets along with playmates
☐ Prone to fight with playmates
☐ Never talks to others
☐ Not much help at home
☐ Seldom completes a task
☐ Learns easily
☐ Enjoys his meals
☐ Resists going to bed
☐ Takes criticism well
☐ Upset by criticism
☐ Talks constantly
☐ Feels inferior
☐ Lacks imagination
☐ Wants his own way

Parent/Guardian Signature: _____ Date: _____