

# KENT CITY SCHOOLS INFORMATION FOR KINDERGARTEN TEACHER

Date: \_\_\_\_\_

Student's Name: \_\_\_\_\_  
Last First Middle

Name Used: \_\_\_\_\_

Address: \_\_\_\_\_

Birthdate: \_\_\_\_\_  
Month/Day/Year

Sex: M F

Check group experience(s) child has had:

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Kent City Schools Preschool: Half-day Full-day | <input type="checkbox"/> Safety Town   | <input type="checkbox"/> Day Care Center    |
| <input type="checkbox"/> Head Start Preschool: Half-day Full-day        | <input type="checkbox"/> Church School | <input type="checkbox"/> Library Story Hour |
| <input type="checkbox"/> Kent State Child Development Center            | <input type="checkbox"/> Other _____   |   |

When your child plays by himself, what are his/her favorite indoor activities? \_\_\_\_\_

Favorite outdoor activities? \_\_\_\_\_

When your child plays with others, what are his/her favorite indoor activities? \_\_\_\_\_

Favorite outdoor activities? \_\_\_\_\_

Does child have his/her own room? Yes No He/She shares room with \_\_\_\_\_

How does your child get along with other children? Good Average Poor With adults? Good Average Poor

Does he/she have playmates of his/her own age? Yes No

How does your child feel about starting kindergarten? Does he/she have any concerns of which we should be aware? Explain: \_\_\_\_\_

List any special fears (dark, storms, animals, insects, etc.): \_\_\_\_\_

Does he/she sleep: \_\_\_\_\_ Soundly \_\_\_\_\_ Lightly \_\_\_\_\_ Restlessly

What methods of discipline are used with your child? \_\_\_\_\_

Does your child have any behavior which disturbs other people in the home? \_\_\_\_\_

Please add any other information about your child's early history or growth that will give us a better understanding of him/her: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## HEALTH

General Health \_\_\_\_\_

List serious illnesses/accidents/surgeries \_\_\_\_\_

Allergies (medication, food) \_\_\_\_\_

List all medications currently taking \_\_\_\_\_

Indicate any eye, ear, or speech difficulties \_\_\_\_\_

Does he/she have any physical disabilities? \_\_\_\_\_

Does he/she have any nervous habits? Explain \_\_\_\_\_

Information given by: \_\_\_\_\_  
(Name)

