KENT CITY SCHOOLS
INFORMATION FOR KINDERGARTEN TEACHER

Date: _____

Student's Name: _____ Name Used: _____
Last First Middle

Address: _____

Birthdate: _____ Sex: ☐ F ☐ M
Month/Day/Year

Check group experience(s) child has had:

☐ Kent City Schools Preschool
☐ Head Start Preschool: Half-day Full-day
☐ Kent State Child Development Center
☐ Safety Town
☐ Church School
☐ Other _____
☐ Day Care Center
☐ Library Story Hour

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)