VPK Parent Questionaire

Dear Parents,

Please fill out the below questionnaire to help us provide your child with a smooth transition and a successful child care experience. *Thank you!*

Child's Name: _____ DOB: _____

Physical Development

(Please check under the word that best describes your child's ability in the following areas):

	Good	Average	Needs Help	Not Applicable
Uses scissors				
Uses crayons				
Uses pencils				
Climbs				
Walks				
Runs				
Hops on 1 foot				
Jumps				

Communication Skills

(Please check under the word that best describes your child's communication skills):

	Good	Average	Needs Help	Not Applicable
Uses words to express self				
Speaks clearly				
Vocabulary is age-appropriate				
Understands direction				

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Does your child have any special habits (thumb-sucking, nail biting, etc.)?

Can your child occupy himself/herself, and for how long?

How does your child express frustration?

What makes your child angry, and how does he/she express anger?

What method of discipline do you use with your child? How does he/she respond?

How does your child react to new situations? How does he/she react when you leave him/her?

List your child's favorite activities:

What descriptive words describe your child?

How do you and your family spend time together?

Please describe his/her Sleeping Habits:

My child usually naps: ____ times a day From: To:

My child sleeps at night from: _____ pm to _____ am

Does your child have any sleep disturbances?

Does your child sleep with any special toy or object?

Does your child sleep in his/her crib at night? _____Yes _____ No
(If no, explain)

_____

Eating Habits:

Does your child have a good appetite? _____Yes _____ No

What foods does your child like or dislike to eat?

Does your child feed himself/herself? _____Yes _____ No

Any eating problems/allergies we should know about?

Toileting:

Is your child fully trained? _____Yes _____ No

Does your child ask to go to the bathroom? _____Yes _____ No

Does your child need help going to the bathroom? _____Yes _____ No

If toilet training is in the process, please describe routines/methods you use:

Self-Help Skills:

Does your child? _____ Dress _____ Undress _____ Button

_____ Zipper _____ Tie Shoes

What responsibilities does your child have around the house?

Does your child accept responsibilities willingly (putting away toys, etc.)?

Special Medical Considerations:

Please list any:

Does your child have any distinguishing birthmarks?

Parent Expectations:

What are your goals/expectations for your child at our center?

Do you have any special concerns or questions to which you would like to draw our attention?

How would you like to participate in our program?

_____ share a special skill/interest:_____

_____ assist with a classroom activity:_____

_____ join us for special events:_____

_____other:_____

_____ _____

(Signature of Parent or Legal Guardian) (Date)

Academic Year:_____