

RED DEER CATHOLIC REGIONAL DIVISION #39
PRE-KINDERGARTEN PARENT QUESTIONNAIRE

Child's Name: _____ **D.O.B.** _____

Please complete the following questions and checklists to assist the selection committee with determining your child's strengths and needs. *It is beneficial for all children prior to entering school to be seen by both a physician and optometrist. Please make arrangements for your child to be seen by these professionals.*

Has your child experienced any of the following? If yes, please provide additional information.

- | | |
|---|--|
| <input type="checkbox"/> vision difficulties | <input type="checkbox"/> extreme shyness |
| <input type="checkbox"/> hearing difficulties | <input type="checkbox"/> anxiety |
| <input type="checkbox"/> high fevers (104+) | <input type="checkbox"/> headaches |
| <input type="checkbox"/> surgery – if yes, what type? | <input type="checkbox"/> temper tantrums/over reacts |
| <input type="checkbox"/> seizures – if yes, what type? | |
| <input type="checkbox"/> ear infections - if yes, how many? | |
| <input type="checkbox"/> allergies – if yes, what type? | |
| <input type="checkbox"/> personal hygiene (bladder or bowel control difficulties) | |

Please record any additional information that may be helpful to the school:

Has your child been diagnosed with any of the following? If yes, please attach any applicable documentation.

- | | |
|---|---|
| <input type="checkbox"/> hearing loss | <input type="checkbox"/> Pervasive Developmental Disorder |
| <input type="checkbox"/> vision loss | <input type="checkbox"/> Fetal Alcohol Spectrum Disorder |
| <input type="checkbox"/> brain injury | <input type="checkbox"/> Autism Spectrum Disorder |
| <input type="checkbox"/> memory loss | <input type="checkbox"/> Attention Deficit Disorder |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Oppositional Defiant Disorder |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Conduct Disorder |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> cognitive delay |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> developmental delay |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> communication delay |
| <input type="checkbox"/> Encephalitis | <input type="checkbox"/> childhood depression |
| <input type="checkbox"/> emotional disability | <input type="checkbox"/> other _____ |

Please record any additional information that may be helpful to the school:

Has your child accessed any of the following services:

- | | |
|---|---|
| <input type="checkbox"/> Speech/Language Pathology | <input type="checkbox"/> Pediatric Rehabilitation Program |
| <input type="checkbox"/> Occupational Therapy | <input type="checkbox"/> Glenrose Hospital, Edmonton |
| <input type="checkbox"/> Physical Therapy | <input type="checkbox"/> Alberta Children's Hospital, Calgary |
| <input type="checkbox"/> Psychology/Psychiatry | <input type="checkbox"/> Children's Services Centre, Red Deer |
| <input type="checkbox"/> Early Intervention Program | <input type="checkbox"/> Program Unit Funding (PUF) |

___ Alberta Mental Health
___ Gifted Funding

___ Mild / Moderate Funding
___ other: _____

Please provide the date of assessment/therapy, therapist’s name and name of agency and any other pertinent information, including past or upcoming appointments:

English as a Second Language (ESL) Eligibility

A student is eligible for ESL support when the primary language spoken at home is a language other than English. ESL students can be Canadian-born or foreign-born.

Does your child qualify for ESL? ___ Yes ___ No

If ‘Yes’, is your child ___ Canadian-born ___ Foreign-born

What languages are spoken at home? _____

What is the primary language spoken at home? _____

Are there concerns with your child’s development in their non-English spoken language?

___ Yes ___ No

Speech Language Development

Do you have any concerns regarding your child’s speech and/or language development?

Yes ___ No ___

Please complete the following checklist:

Has your child been seen by a SLP before or do they have an appointment booked?

Yes No

I. Speech Sound Development

A. Is your child 80-90% understandable to strangers? Yes No

B. Normal sound development.

Normal sound errors for children in this age range include: s z r l th r

If your child has difficulty with any of the sounds listed above, please circle and provide an example.

C. Does your child have difficulties saying the following words/sounds?

P - pop	Yes <input type="checkbox"/>	No <input type="checkbox"/>
B - bib	Yes <input type="checkbox"/>	No <input type="checkbox"/>
M - mom	Yes <input type="checkbox"/>	No <input type="checkbox"/>
N - nine	Yes <input type="checkbox"/>	No <input type="checkbox"/>
T - tot	Yes <input type="checkbox"/>	No <input type="checkbox"/>
D - dad	Yes <input type="checkbox"/>	No <input type="checkbox"/>
W - win	Yes <input type="checkbox"/>	No <input type="checkbox"/>
H - hot	Yes <input type="checkbox"/>	No <input type="checkbox"/>
F - fun, knife	Yes <input type="checkbox"/>	No <input type="checkbox"/>
K - cake	Yes <input type="checkbox"/>	No <input type="checkbox"/>
G - gag	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Sh - shush	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Ch - chin	Yes <input type="checkbox"/>	No <input type="checkbox"/>
J - jam	Yes <input type="checkbox"/>	No <input type="checkbox"/>

II. Language Development

A. Expressive

1. Do your child's sentences sound immature?

(Short in length, words not in the correct order, words omitted, their message is difficult to understand).

Yes No

2. Does your child have **difficulty** using the following grammatical structures appropriately on a consistent basis?

• Pronouns Yes No

Please circle those **NOT** used

he she they I you we

If you have circled any please indicate what your child uses instead.

• Possessive pronouns Yes No

Please circle those **NOT** used

his hers yours mine

If you have circled any please indicated what your child uses instead.

• Past tense ed Yes No

i.e. He walked fast

She talked loud

If yes, please indicate what your child uses instead.

• Plural /s/ Examples: cats books Yes No

ez/ Examples: glasses dishes

• Negatives – examples include: Yes No

can't/don't won't doesn't

Please circle those you have heard your child say.

B. Receptive Language

1. Does your child have difficulty understanding questions or following directions?
(puzzled look, doesn't respond, answers inappropriately)

Yes No

III. Fluency (Stuttering)

Does your child repeat words or parts of words?

Yes No

i.e. I I I I want a drink

C C Can I have a drink?

IV. Hearing

Do you have concerns about your child's hearing?

Yes No

Does your child have a history of middle ear infections?

Yes No

Do you feel that your child is academically advanced in comparison to his/her peers?

Yes _____ No _____

If yes, please explain. _____

Please rate your child on a scale of 1 to 5, with 5 being the highest, on the following skills:

MOTOR SKILLS	Rarely		Sometimes		Always
Catching objects with 2 hands:	1	2	3	4	5
Catching objects with 1 hand:	1	2	3	4	5
Jumping:	1	2	3	4	5
Hopping (on right foot- # of hops)	1	2	3	4	5
Hopping (on left foot-# of hops)	1	2	3	4	5
Skipping:	1	2	3	4	5
Cutting:	1	2	3	4	5
Copying/drawing shapes:	1	2	3	4	5
Printing Name:	1	2	3	4	5

Do you have any concerns in this area? ____Yes ____ No (If Yes, Please Comment Below)

CONCEPTS

Naming body parts:	1	2	3	4	5 (names 9 body parts)
Color recognition:	1	2	3	4	5 (names 7 colors)
Rote counting:	1	2	3	4	5 (25+)
Shape identification:	1	2	3	4	5 (names 5 shapes)
Concepts (ie. under, between, empty, longest, littlest, most, in front of, around, night and the opposite of each word)	1	2	3	4	5 (names 18 concepts)

Do you have any concerns in this area? ____Yes ____ No (If Yes, Please Comment Below)

LANGUAGE

Knows first name:	1	2	3	4	5 (all of the time)
Knows last name:	1	2	3	4	5 (all of the time)
Knows age:	1	2	3	4	5 (all of the time)
Knows birthday:	1	2	3	4	5 (all of the time)
Alphabet song:	1	2	3	4	5 (26 letters identifiable)
Letter naming:	1	2	3	4	5 (26 letters)
Letter sound correspondence:	1	2	3	4	5 (26 letters)
Rhyming words:	1	2	3	4	5 (rhymes 3 letter words)
Short-term memory:	1	2	3	4	5 (repeats 3 steps)
Long-term memory:	1	2	3	4	5 (recalls factual information)
Completes puzzle:	1	2	3	4	5 (25 pieces)

Do you have any concerns in this area? Yes No (If Yes, Please Comment Below)

SELF-HELP DEVELOPMENT

	Rarely		Sometimes		Always
Puts toys away when asked	1	2	3	4	5
Buttons large buttons	1	2	3	4	5
Washes and dries hands	1	2	3	4	5
Brushes teeth	1	2	3	4	5
Brushes or combs hair	1	2	3	4	5
Put shoes on correct feet	1	2	3	4	5
Uses toilet	1	2	3	4	5
Blows and wipes nose without being asked	1	2	3	4	5

Do you have any concerns in this area? Yes No (If Yes, Please Comment Below)

SOCIAL DEVELOPMENT

	Rarely		Sometimes		Always
Sticks to one activity for at least 15 minutes at a time	1	2	3	4	5
Accepts limits without getting upset	1	2	3	4	5
Plays well with others	1	2	3	4	5
Stops an activity when parents say	1	2	3	4	5
Keeps working at something until it is finished	1	2	3	4	5
Is well liked by other children	1	2	3	4	5
Waits his or her turn in games	1	2	3	4	5
Over-reacts or has temper tantrums	1	2	3	4	5
Uses words rather than physical actions to settle arguments with other children	1	2	3	4	5
Reacts in ways parents can predict	1	2	3	4	5
Is easily frustrated	1	2	3	4	5
Asks permission to use something that belongs to someone else	1	2	3	4	5

Do you have any concerns in this area? Yes No (If Yes, Please Comment Below)

Please provide additional comments and reasons for referring your child, that you feel would be pertinent in determining your child's eligibility.
