Frankford Township School District

Robert Mooney
Superintendent/Elementary Principal
mooneyr@frankfordschool.org

David Sylvester
Middle School Principal
sylvesterd@frankfordschool.org

Preschool Parent Questionnaire

Date: ___________________

Child's Information

Name ______________________________________ Male ___ Female___

Home Address: Street___________________________________

Town __________________________________ State ____ Zip ____________

Who's completing questionnaire? ______________________(mother, father, relative, caregiver, guardian, other)

Date of Birth _____________________(m/d/year)

Family Information

Mother's Name _______________________________

Home Address: ____ Same as Child

Street ____________________________________

Town ________________________________ State _______ Zip ___________

Phone _________________________ Date of Birth ____________ (m/d/year)

Email address _________________________________

Highest Education Completed __________________________________

Occupation (specific)____

Father's Name ______________________________

Home Address: ____ Same as Child

Street _________________________________

Town ______________________________ State _______ Zip __________

Phone ____________________________ Date of Birth ________________

Email address _______________________________

Highest Education Completed ________________________________

Occupation (specific) ______________________________________

Other Family Information

With whom has the lived with most of the past year? ___Mother ___Father
___Both ___Guardian ___ Other (specify)_______________________

Other children in the family - How many? _________
Names/Ages

____

____

____

____

____

Other people living in the household _____________________________

What language(s) are spoken at home?

___English ____ Other (specify) _____________

Medical History

Birth

Were there any significant problems during pregnancy? ___ Yes ___No
If yes, please explain:

Was your child more than 3 weeks premature? ____Yes ___No

If yes, how many weeks premature? _______________

Baby's birth weight ____________________

Did the baby stay in the hospital longer than the mother? ____Yes ___ No

If yes, please explain

____

____

____

At time of birth, did the baby have seizures? ____Yes ____No
Turn blue? ____Yes ____No

Child's Health History Since Birth

Eyes Has your child ever had trouble seeing? ___Yes ___No
Does your child hold objects close to his/her face? ___Yes ___No
Have your child's eyes ever looked crossed? ___Yes ___No
Do you suspected your child has a vision problem? ___Yes ___ No

If yes, explain concern:

Ears Has your child had frequent ear infections? ___Yes ___ No
Has your child ever had trouble hearing? ___ Yes ___No
Have you ever suspected that your child has a hearing problem? ___ Yes. ___No

If yes, explain concern:

Coordination

Has your child ever had trouble walking, climbing, reaching, holding on to things? ___Yes ___No

If yes, explain concern:

Has your child ever had any significant injuries or hospitalizations? ___Yes __No
If yes, please explain:

Does your child have any allergies? ___Yes ___No
If yes, please describe:

Is your child presently on any medications? ___Yes ___No
If yes, please explain:

Please share any other health concerns you would like to share.

Child Development/Personality

Can your child feed him/herself using a spoon and/or fork? ___Yes ___No
Can your child wash and dry his/her own hands? ___Yes ___No
Can your child help with dressing/dress with little assistance? ___Yes ___No
Can your child speak so that he/she can be understood by others? ___Yes ___No
Can your child express his/her thoughts or needs easily? ___Yes ___No

Do you have any concerns about your child's appetite or willingness to try different foods? ___Yes ___ No
If yes, please explain:

Do you have any concerns about your child's sleep patterns? ___Yes ___No
(difficulty getting to sleep, wakes frequently during night) If yes, please explain:

Is your child- Highly active ___Yes ___No
Very quiet ___Yes ___No

Is your child toilet trained during the day? ___Yes __No
in need of help toileting? ___Yes ___No

My child ... (please check all that apply to your child's typical behavior)

___ plays with blocks, boxes, cups, or other construction toys without help

___uses crayons and/or marker to scribble or draw

___ listens to stories when read

___ turns pages of a book and looks at the pictures

___ recalls stories or events

___ can play alone for a short period of time

___ talks to family members, friends, and visitor to our home

___ follows simple directions

Please describe your child's favorite activities:

Does your child have opportunities to play with other children? ___Yes ___No

How many hours a day does your child spend watching TV on using a tablet or computer device? __________

Please describe your child:

Are there other things you would like to tell us about your child?