ECNS Questionnaire

Child's full name_____________________________________ Class _______________ Birthdate _____________

In school, please call my child ________________________________

Date ____________________ Parents' names____

Person completing this form ____

ALL e-mail addresses for school notices____

____

Family Information

Who lives with your child? Please provide name and relation (e.g. Emily, older sister) and age/school if applicable:

Name/Relationship Age/School

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____

____

Who are other important people in your child's life? What are their relationships to your child and what does your child call them? (e.g. maternal grandfather, our child calls him "Papa") ______________________________________

____

Do you have pets in your home? ( ) Yes ( ) No

If "yes", what are they and what does your child call them? ____

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What, if any, holidays or special days do you celebrate in your home (e.g. Gotcha Day, Hanukah, Chinese New Year)?

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What languages are spoken in your home? ____

Behavior/Experience/Routines

What time does your child typically go to bed in the evening and wake up in the morning? __________________

Does your child share a bedroom? If yes, with whom?____

What activities do you enjoy doing as a family?____

Do you regularly read to your child? ( ) Yes ( ) No

Has your child had experiences with crayons? ( )Yes ( )No -Paint? ( )Yes ( )No -Scissors? ( )Yes ( )No

Are there any special concerns about your child? (i.e.anxiety,fears,separation)

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Is your child toilet trained, including being dry at night? ( ) Yes ( ) No
If "no", where is your child in the process and what strategies are being used?
____

Does your child have a special stuffed animal, blanket or other object? ( ) Yes ( ) No
If yes, what is your child's name for this object? ____

How does your child interact with screen time (movies, TV, video games, computers, phones, etc.)? and what is their daily exposure (amount of time, place, etc.)? ____

____

How and when are meals served in your family? ____

How does your child help at home? ____

What qualities do you like most in your child? ____

Does your child have food allergies? ( ) Yes ( ) No
If yes, please explain and get a medical form from the office for any medication to be left at school. ___________

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Does your child have a history of ear problems or any chronic health issues? ( ) Yes ( ) No
If yes, please explain.____

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Are you enrolled in Parents As Teachers? ( ) Yes ( ) No

Has your child been enrolled in First Steps or received any developmental therapy (such as speech and language, occupational therapy, etc.)? ( ) Yes ( ) No If yes, please explain. If your child has an "IEP", please provide the nursery school with a copy. ____

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Have there been any experiences that might affect your child (i.e. divorce, illness, death, recent move)?
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Goals and Outcomes

What do you hope your child will gain from the nursery school experience? ______________________________

____

Would you like to participate in your child's pre-school experience (talent to share, field trips, etc.)? _____________

____

Is there anything else you think we should know about your child? ______________________________

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Thank you for taking the time to complete this. We look forward to a great school year!