



# PEREGIAN SPRINGS STATE SCHOOL

## PREP PARENT QUESTIONNAIRE

Child's Name:		Date of Birth: __/__/__
Parent/ Guardian:		Relationship to child:
Parent/ Guardian:		Relationship to child:
Parent/ Guardian:		Relationship to child:
Parent/ Guardian:		Relationship to child:
Custody/Guardianship information:		
Is your child the <input type="checkbox"/> <b>youngest</b> <input type="checkbox"/> <b>eldest</b> <input type="checkbox"/> <b>middle</b> <input type="checkbox"/> <b>only</b> child in your family?		
Name and year level of siblings if applicable:		
Who are the people your child lives with?		
Has there been recent changes in your family? (E.g. recent move, new baby, marriage, divorce, death)		
How will your child usually travel to and from school? <input type="checkbox"/> car <input type="checkbox"/> bus <input type="checkbox"/> walk <input type="checkbox"/> bike <input type="checkbox"/> other		
Has your child participated in a Queensland Government-approved Kindergarten program? <input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b> If yes, please provide details.		
<b>Provider 1:</b> _____ <b>Teacher</b> _____ <input type="checkbox"/> Monday <input type="checkbox"/> Tuesday <input type="checkbox"/> Wednesday <input type="checkbox"/> Thursday <input type="checkbox"/> Friday <input type="checkbox"/> N/A		
<b>Provider 2:</b> _____ <b>Teacher</b> _____ <input type="checkbox"/> Monday <input type="checkbox"/> Tuesday <input type="checkbox"/> Wednesday <input type="checkbox"/> Thursday <input type="checkbox"/> Friday <input type="checkbox"/> N/A		
Please Note: Your child's kindergarten <b>transition statement</b> is a key element in understanding your child's learning needs and capabilities. It is a vital element in ensuring a smooth transition, and request that you share this document with the school once received.		
<b>PHYSICAL DEVELOPMENT</b>		
At what age did your child crawl?		Walk?
Has your child had any serious illnesses, operations, or accidents? <input type="checkbox"/> No <input type="checkbox"/> Yes (Please provide details)		
Does your child have any allergies? <input type="checkbox"/> No <input type="checkbox"/> Yes (Please provide details)		
Does your child still have a daytime rest/sleep? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Can your child toilet themselves? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Do you have any concerns about your child's development? (Please provide details)		
<b>Eyesight</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Hearing</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Speech</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Physical Co-ordination</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>Four year old health checks:</b> Any arising issues? (Please provide details)		
Does your child have a NDIS plan? <input type="checkbox"/> No <input type="checkbox"/> Yes (Please provide details)		

SPECIALIST SERVICES			
Has your child seen any of the following services?	Yes	No	Please provide details:
Speech Language Pathologist?			
Occupational Therapist?			
Physiotherapist?			
Paediatrician?			
Optometrist?			
Audiologist?			
Other?			
LANGUAGE DEVELOPMENT			
What is the main language spoken at home?			
At what age did your child start to talk?			
How well does your child listen to and follow instructions?			
Can your child recognise their name? <input type="checkbox"/> Yes <input type="checkbox"/> No      Write their name? <input type="checkbox"/> Yes <input type="checkbox"/> No			
MOTOR DEVELOPMENT			
What is your child's most dominant hand? <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Unsure			
Has your child been exposed to using- <b>Writing equipment?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Scissors?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Glue?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <small>(eg pencils, crayons)</small>			
SOCIAL AND EMOTIONAL DEVELOPMENT			
How does your child react when you leave them in someone else's care?			
How do you think your child will react to starting Prep?			
What opportunities has your child had to socialise with other children their own age? <input type="checkbox"/> Day Care <input type="checkbox"/> Family Day Care <input type="checkbox"/> Kindergarten <input type="checkbox"/> Other (Please provide details)			
Does your child prefer to play with others or alone? (Please provide details)			
How does your child react to change, new challenges and frustration? (Please provide details)			
Do you have any concerns about your child's social emotional development? (Please provide details)			
HOME ACTIVITIES			
What are your child's interests?			
Does your child participate in any 'out-of-school' activities? (e.g. soccer, dancing, gymnastics, piano, football)			
What sort of technology (e.g. computer, iPad etc) does your child use at home? How often?			
CULTURAL CONSIDERATIONS			
Does your child require any special considerations for: <input type="checkbox"/> Food <input type="checkbox"/> Clothing <input type="checkbox"/> Celebrations <input type="checkbox"/> Sports Activities <input type="checkbox"/> Other (Please provide details)			
HOPES FOR MY CHILDS PREP YEAR			