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 ☐ **youngest** ☐ **eldest** ☐ **middle** ☐ **only** 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? ☐ car ☐ bus ☐ walk ☐ bike ☐ other	
Has your child participated in a Queensland Government-approved Kindergarten program? ☐ **Yes** ☐ **No** If yes, please provide details. **Provider 1:** _____ Teacher _____ ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ N/A **Provider 2:** _____ Teacher _____ ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ N/A Please Note: Your child's kindergarten **transition statement** 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.	
PHYSICAL DEVELOPMENT	
Was your child born at full term? ☐ Yes ☐ No If premature, how early?	
Were there any complications during birth?	
At what age did your child crawl?	Walk?
Has your child had any serious illnesses, operations, or accidents? ☐ No ☐ Yes (Please provide details)	
Does your child have any allergies? ☐ No ☐ Yes (Please provide details)	
Does your child still have a daytime rest/sleep? ☐ Yes ☐ No	
Can your child toilet themselves? ☐ Yes ☐ No	
Do you have any concerns about your child's development? (Please provide details) **Eyesight** ☐ Yes ☐ No **Hearing** ☐ Yes ☐ No **Speech** ☐ Yes ☐ No **Physical Co-ordination** ☐ Yes ☐ No **Four year old health checks:** Any arising issues? (Please provide details)	
Does your child have a NDIS plan? ☐ No ☐ 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? ☐ Yes ☐ No Write their name? ☐ Yes ☐ No

MOTOR DEVELOPMENT

What is your child's most dominant hand? ☐ Left ☐ Right ☐ Unsure

Has your child been exposed to using-

Writing equipment? ☐ Yes ☐ No **Scissors?** ☐ Yes ☐ No **Glue?** ☐ Yes ☐ No

(eg pencils, crayons)

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?

☐ **Day Care** ☐ **Family Day Care** ☐ **Kindergarten** ☐ **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:

☐ Food ☐ Clothing ☐ Celebrations ☐ Sports Activities ☐ Other (Please provide details)

HOPES FOR MY CHILDS PREP YEAR