

Seattle Christian Schools Kindergarten Questionnaire

Name _____ Sex _____ Grade entering _____

Name child goes by _____ Birthdate _____ Age _____

- | | YES | NO |
|--|--------------------------|--------------------------|
| 1. Has this child been tested for or diagnosed with any medical, behavioral developmental or psychological condition? (i.e. learning disability, ADD/ADHD, depression, or any other condition that would affect his/her performance at school? Please explain.) | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Has your child ever had (or been evaluated for) an IEP (individual education plan) or received 504 accommodations? (Please explain) | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Is your student taking any type of medication? (If yes, for what purpose are they used?) | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Does he/she have normal vision? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Does he/she enjoy normal hearing? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Is this child currently in preschool? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Has this child had any problems at school? (If yes, please explain.) | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Does this child still take naps during the day? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Does this child show interest in spiritual matters? (If yes, please elaborate.) | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. What are your child's play habits? | | |
| 11. What are your child's fears? | | |

Pre School: _____

Address: _____ City _____ Zip _____

Parents' Name (please print) _____

Parents' phone _____ Email: _____

Date _____ Signature _____

Father/Mother/Guardian