



**Kindergarten Registration Form
2019-2020**

Please Print

Date: _____

Student Name: _____
Last First Middle

Sex: Male Female Date of Birth: _____ City of Birth: _____

Home School: _____

Parent/Guardian: _____
Name Relationship Address

Parent/Guardian: _____
Name Relationship Address

Email: _____
Parent/Guardian Parent/Guardian

Phone: _____
Parent/Guardian Home Cell Parent/Guardian Home Cell

• I would like my child in half-day kindergarten in 2019/2020 Yes No

• I would like my child in full-day kindergarten in 2019/2020 Yes No

• My preference for my child's placement in full-day kindergarten in 2019/2020 is as follows (Please check only one) Home School Kindergarten Center No Preference

• I would like to be considered for Reduced Tuition under the State Guidelines of Being Economically Disadvantaged for full-day kindergarten Yes No
*** See attached sheet with information*

Parent/Guardian Signature(s): _____
Parent/Guardian Parent/Guardian



New Student/Parent Questionnaire

Dear Parent/Guardian:

This questionnaire is designed to help us understand your child as much as possible in order to facilitate his/her successful entry into school. Please feel free to add any additional information about your child that you think may be helpful toward this goal. Please respond to only those questions with which you feel comfortable. All information will be held confidential.

Today's Date _____

School of Entry _____

Child's Full Name _____
First Middle Last

Date of Birth _____ Place of Birth _____

Family:

Person completing this form Parent/Guardian1 Parent/Guardian2 Other _____

Address _____ Phone No. _____

Parent/Guardian 1's Name _____ Date of Birth _____

Place of Birth _____ Occupation _____

Parent/Guardian 2's Name _____ Date of Birth _____

Place of Birth _____ Occupation _____

Status of Parents/Guardians (i.e., married, divorced, etc.) _____

Who has legal custody? _____

If parents are separated, what is the schedule for visitation with the other parent?

New Student/Parent Questionnaire

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Children: Please list your children below in the order that they were born, beginning with the oldest. Include the child you are bringing in his/her proper order in the listing.

| Name | Sex | Birth Date | School | Grade | Adopted/date |
|------|-----|------------|--------|-------|--------------|
| 1. | | | | | |
| 2. | | | | | |
| 3. | | | | | |
| 4. | | | | | |
| 5. | | | | | |
| 6. | | | | | |

Are there any children at home with special issues (i.e., medical, emotional, disciplinary, or related to school achievement)? If so, please list child and explain:

Does anyone else live in your home? If so, who and for how long? _____

Child's prior experience in Day Care programs and/or nursery schools:

| Place | From (Date) | Until (Date) |
|-------|-------------|--------------|
| | | |
| | | |
| | | |

Language, other than English, which is spoken to the child is: _____

Most of the time Frequently Occasionally

Which member(s) of the family converse with the child in this language? _____

Your child's special interests and activities are: _____

Special home considerations that might interfere with your child's school functioning include:

Please describe your child's social skills (ability to make friends, get along with others, etc).

What do you believe is your child's best academic subject? _____

What do you believe is your child's least favorite subject? _____

Please describe your child's favorite free-time activities (read, watch TV, play outdoors, etc.)

Please describe any issues for your child that would interfere with his/her success at school (academic, social, emotional, physical, home, etc.) _____

List moves within the past five years: _____

Please check any of the following which are problems with this child:

- | | |
|--|---|
| <input type="checkbox"/> Running Away | <input type="checkbox"/> General Anxiety |
| <input type="checkbox"/> Bedwetting | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Temper Tantrums | <input type="checkbox"/> Stomach Aches |
| <input type="checkbox"/> Nail Biting | <input type="checkbox"/> Fears/Phobias |
| <input type="checkbox"/> Nightmares | <input type="checkbox"/> Over Dependency |
| <input type="checkbox"/> Resentment | <input type="checkbox"/> Over Sensitivity |
| <input type="checkbox"/> A "Loner" | <input type="checkbox"/> Destructiveness |
| <input type="checkbox"/> Over Activity | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Self-Critical | |

Add any information or comments you would like to this form regarding any of the above mentioned conditions. Use back of paper if necessary: _____

Sleep/Bedtime Habits:

Falls asleep in reasonable time Yes No If not, please explain: _____

Wakes during night Yes No Sleepwalks Yes No Talks in Sleep Yes No

Miscellaneous:

Does your child:

- Watch more than 3 hours of TV daily? Yes No
- Turn on the TV at a very high volume? Yes No
- Say "what, what" all the time? Yes No
- Sit very close to the TV screen? Yes No

Extended Family History (cousins, uncles, aunts, parents, etc.):

Do any family members have the following, and if so, please explain briefly:

- Long term illnesses or birth defects _____
- Muscular difficulties _____
- Seizure disorders _____
- Vision loss _____
- Hearing loss _____
- Alcohol disorders _____
- Nervous disorders _____
- Learning Difficulties _____
- Reading Problems _____
- Math Problems _____
- Speech problems (deficits) _____
- Retention _____

Has your child been evaluated elsewhere? Yes No

If so, why and where? _____

May we contact them? Yes No

If there is anything further you wish to mention about your child, please feel free to comment: _____



Early Childhood Education Experience Survey

Preschool Experience prior to **Kindergarten**-(For Incoming K Students only)

Student First Name: _____

Please enter legal first name of student (no nicknames please)

Student Last Name: _____

Elementary school child will attend:

- | | |
|--|---|
| <input type="checkbox"/> Flaherty Elementary | <input type="checkbox"/> Highlands Elementary |
| <input type="checkbox"/> Hollis Elementary | <input type="checkbox"/> Liberty Elementary |
| <input type="checkbox"/> Morrison Elementary | <input type="checkbox"/> Ross Elementary |

Early Childhood Experience - Please check the box that best describes your child's preschool experience in the school year prior to entering kindergarten. Select one option only.

- 01 -My child did not have any formal early childhood program experience
- 02-My child did not have formal early childhood program experience but participated in local based programs that are parent/child playgroups and activities
- 03-My child did not have formal early childhood program experience but participated in home visiting program through Dept. of Early Education.
- 04-My child did not have formal early childhood program experience but participated in BOTH local based programs that are parent/child playgroups and activities AND home visiting program through Dept. of Early Education.
- 05-My child attended a licensed Family Child Care Provider - less than 20 hours per week
- 06-My child attended a licensed Family Child Care Provider - more than 20 hours per week
- 07-My child attended a licensed Preschool Center (such as Headstart, public and private preschools)-less than 20 hours per week
- 08-My child attended a licensed Preschool Center (such as Headstart, public and private preschools)-more than 20 hours per week
- 09-My child attended BOTH a licensed Family Child Care Provider and a licensed Preschool Center-less than 20 hours per week
- 10-My child attended BOTH a licensed Family Child Care Provider and a licensed Preschool Center-more than 20 hours per week