LEE CHRISTIAN SCHOOL
KINDERGARTEN INFORMATION FORM

Information about your Child for the School Record Date_____

Child's Name_____ Nickname_____

Check ( ) appropriate answer

1. Does your child say the alphabet without singing it? Yes____ No____
2. Does your child identify the uppercase and lowercase alphabet letters from flash cards in random order? Yes____ No____
3. Does your child know his/her first and last name? Yes____ No____
4. Does your child recognize his/her last name in print? Yes____ No____
5. Does your child write his/her first name with first letter upper case and remaining letters lower case? Yes____ No____
6. Does your child identify the eight basic colors? Yes____ No____
7. Does your child color within the lines? Yes____ No____
8. Does your child count from 0-20? Yes____ No____
9. How far can your child count? _____
10. Does your child identify numbers 0-9? Yes____ No____
11. Does your child identify numbers 10-19? Yes____ No____
12. Does your child seem to be clumsy or awkward? Yes____ No____
13. Does your child have difficulty manipulating small objects (pegs, beads)? Yes____ No____
14. Does your child have difficulty using scissors? Yes____ No____
15. Does your child have difficulty coloring? Yes____ No____
16. Does your child have difficulty with dressing such as distinguishing front or back of clothing, fastening buttons, zippers, or snaps? Yes____ No____
17. Does your child have difficulty using eating utensils? Yes____ No____
18. Does your child tend to switch hands while using utensils, pencils, or scissors? Yes____ No____
19. Does your child have difficulty building structures with Legos, blocks, Lincoln Logs, Tinker Toys, etc? Yes____ No____
20. Does your child become easily frustrated with these activities? Yes____ No____
21. Does your child dislike being touched? Yes____ No____
22. Does your child refuse to wear certain types of clothing? Yes____ No____
23. Is your child fearful of movement or playground equipment such as slides or swings? Yes____ No____
24. Does your child get dizzy easily? Yes____ No____
25. Does your child get car sick? Yes____ No____

26. Does your child usually get dizzy after a lot of spinning or rolling? Yes____ No____

27. Is your child easily distracted? Yes____ No____

28. Is your child slow to complete daily activities? Yes____ No____

29. Is your child disorganized in completing daily activities? Yes____ No____

30. Does your child lack self-confidence often saying "I can't" or "It's too hard"? Yes____ No____

31. Does your child have difficulty understanding what's going on around him? Yes____ No____

32. Did your child learn to talk, walk, and feed himself at about the same time as other children of the same age? Yes____ No____

33. Does your child have trouble saying some of his words? Yes____ No____

34. Do other people understand what your child is saying? Yes____ No____

35. Do you have to ask questions over and over before your child understands? Yes____ No____

36. Does your child play well with other children? Yes____ No____

37. Does your child like playing alone better than playing with other children? Yes____ No____

38. Does your child bite his nails or exhibit other signs of nervous behavior? Yes____ No____

39. Does your child suck his thumb/fingers? Yes____ No____

40. Is your child a picky eater? Yes____ No____

41. Has your child had previous preschool experience? Yes____ No____
If so, where? _____

HEALTH INFORMATION

1. Has your child ever had any bad accidents or been very sick (broken bones, an injury needing stitches, had a high fever, bad burns or bad head injury)? Yes____ No____
If yes, When? _____
What? _____

2. Has the health nurse or the school nurse ever visited in your home? Yes____ No____
If yes, what was the nurse's name? _____

3. Has your child been to a dentist in the last year? Yes____ No____

4. Does your child wet the bed at night? Yes____ No____
Does your child wet his/her clothes during the day? Yes____ No____
Does your child need to go to the bathroom a lot? Yes____ No____

5. Does your child have trouble controlling his/her bowels? Yes____ No____
Does your child need help cleaning his/her self (after using the restroom)? Yes____ No____

6. Please check if your child has any of the following symptoms or problems:
A lot (3 or more a year) of colds____, sore throats____, earaches____, ever had nosebleeds____, a lot of headaches____, seizures or convulsions____, growing pains____, pains in his/her joints____, ever fainted or passed out____, gets tired easily____. Has your child had chicken pox? Yes____ No____

7. Is there anything the school should know about the health of your child in order to give your child special care?_____
If yes, what? _____

WRITE ON BACK ANY ADDITIONAL INFORMATION THE SCHOOL SHOULD KNOW ABOUT YOUR CHILD?