

Dear Parents,

There will be a kindergarten meeting in the cafe at 8:00 AM on Tuesday, August the 25<sup>th</sup>. I encourage you to bring your child's supplies and forms to this meeting. This will help make the transition to school on Wednesday easier for your child, you, and the teacher. Please make sure that you put your child's name on their beach towel for brain break. This meeting takes place on Back to School night for kindergarteners so your focus will need to be on the information presented. Students are not required to attend this meeting.

God Bless,  
Mrs. Catton

Please fill out and return at kindergarten orientation meeting:

Child's name: \_\_\_\_\_

Mom's email and cell phone:

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Dad's email and cell phone:

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Please indicate who I should contact first if I need to contact a parent

# Holy Spirit

7241 East 10<sup>th</sup> St., Indianapolis IN., 46219 – (317) 352-1243

Please complete all of the forms and bring on the day of your child's scheduled screening.

## EARLY PREVENTION OF SCHOOL FAILURE PARENT OBSERVATION FORM

Name of Child \_\_\_\_\_ Birthday \_\_\_\_\_

Parents Name \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Father occupation \_\_\_\_\_

Mother occupation \_\_\_\_\_

Child family includes

Brother(s) (names & ages)

Sister(s) (names & ages)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please answer the questions on this form in the best way that you can. You will be able to answer some quite easily and you may have difficulty in making a decision on others.

Your answers on this form will help the school staff and will involve you in deciding with the teacher what kind of educational program is best suited for your child.

This questionnaire is confidential and your responses will be shared only with professional personnel and only if the information learned will help in planning an educational program for your child.

Name \_\_\_\_\_

I. General Health History

Please check any health concern that you or your doctor observed:

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Asthma          | <input type="checkbox"/> Bed Wetting           | <input type="checkbox"/> Loss of Conciseness                                 |
| <input type="checkbox"/> Indigestion     | <input type="checkbox"/> Allergies             | <input type="checkbox"/> Fainting  |
| <input type="checkbox"/> Constipation    | <input type="checkbox"/> Serious blows to head | <input type="checkbox"/> Overtired or lacking pep                            |
| <input type="checkbox"/> Diarrhea        | <input type="checkbox"/> Headache              | <input type="checkbox"/> Heart trouble                                       |
| <input type="checkbox"/> Vomiting        | <input type="checkbox"/> Nightmares            | <input type="checkbox"/> Hyperactivity                                       |
| <input type="checkbox"/> Stomachaches    | <input type="checkbox"/> Thumb sucking         |  |
| <input type="checkbox"/> Frequent fevers | <input type="checkbox"/> Nail biting           | <input type="checkbox"/> Medical problems immediately after birth            |
| <input type="checkbox"/> Sinus Trouble   | <input type="checkbox"/> Epilepsy (seizures)   | <input type="checkbox"/> Substance abuse victim                              |
| <input type="checkbox"/> Nose Bleeding   | <input type="checkbox"/> Diabetes              | <input type="checkbox"/> Chronic ear infections*<br>* (more than 2 per year) |

Other physical problem(s) (explain): \_\_\_\_\_

Is the child currently on medication?  Which: \_\_\_\_\_

Has child had any significant injuries or hospitalization? \_\_\_\_\_

Is child healthy on day of assessment? \_\_\_\_\_

II. Hearing Assessment

Has this child ever had any ear/hearing examination or treatment? (Mark one)  Yes  No

When: \_\_\_\_\_ By Whom: \_\_\_\_\_

Results: \_\_\_\_\_

- |   | Yes   | No    |
|---|-------|-------|
| A. Do you suspect hearing problems?   | _____ | _____ |
| B. Does your child:   |       |       |
| 1. Seem to have difficulty hearing?   | _____ | _____ |
| 2. Turn up the TV louder than other members of the family?                    | _____ | _____ |
| 3. Seem to favor one ear over the other?                                      | _____ | _____ |
| 4. Jump or appear to be more startled than others if there is a sudden noise? | _____ | _____ |
| 5. Seem to hear you if you talk in a whisper?                                 | _____ | _____ |
| 6. Make you talk loudly or repeat frequently?                                 | _____ | _____ |
| 7. Become confused in following more than two verbal directions at a time?    | _____ | _____ |
| 8. Have difficulty remembering things for a long time?                        | _____ | _____ |
| 9. Have difficulty remembering things for a short time?                       | _____ | _____ |

Name \_\_\_\_\_

III. Language Development

At what age did your child first begin to speak? Give approximate age if you do not remember exact age:

First words \_\_\_\_\_ Two or three words together \_\_\_\_\_ Sentences \_\_\_\_\_

Does your child

- 1. Stutter? \_\_\_\_\_ Yes \_\_\_\_\_ No
- 2. Have difficulty expressing ideas and concepts? \_\_\_\_\_ Yes \_\_\_\_\_ No

IV. Visual Assessment

Has your child ever had a vision examination or treatment? \_\_\_\_\_ Yes \_\_\_\_\_ No

When? \_\_\_\_\_ By whom? \_\_\_\_\_

Result: \_\_\_\_\_

- |  | Yes   | No    |
|--|-------|-------|
| A. Do you suspect any vision problems?                     | _____ | _____ |
| B. Does your child:  | Yes   | No    |
| 1. Seem to have difficulty seeing small lines or pictures? | _____ | _____ |
| 2. Seem to have a problem seeing things <i>far</i> away?   | _____ | _____ |
| 3. Squint?   | _____ | _____ |
| 4. Wear glasses?   | _____ | _____ |
| 5. Have eyes that turn in?                                 | _____ | _____ |
| 6. Have eyes that turn out?                                | _____ | _____ |
| 7. Sit very close to television?                           | _____ | _____ |
| 8. Rub eyes a lot?   | _____ | _____ |
| 9. Turn head as to use primarily one eye?                  | _____ | _____ |
| 10. Lower one side or the head when looking at others?     | _____ | _____ |

V. Motor Development

The child began walking at (if guess, label as such) Age \_\_\_\_\_  
Yes \_\_\_\_\_ No \_\_\_\_\_

Do you feel your child has adequate large muscle coordination? \_\_\_\_\_

Does your child?

- 1. Catch a ball thrown to him? \_\_\_\_\_
- 2. Enjoy physical activities? \_\_\_\_\_
- 3. Lose balance, trip, and fall more often than "normal"? \_\_\_\_\_
- 4. Have difficulty running? \_\_\_\_\_

Name \_\_\_\_\_

VI. Social Development

Does your child

- |  | Yes   | No    |
|--|-------|-------|
| 1. Have regular playmates the same age?  | _____ | _____ |
| 2. Have difficulty getting along with other children?                                    | _____ | _____ |
| 3. Prefer to play with other children instead of alone?                                  | _____ | _____ |
| 4. Become easily frustrated?   | _____ | _____ |
| 5. Cry often?  | _____ | _____ |
| 6. Have a bad temper?  | _____ | _____ |
| 7. Enjoy cooperating with others?  | _____ | _____ |
| 8. Become frequently irritated or moody?   | _____ | _____ |
| 9. Become upset by changes in routine?   | _____ | _____ |
| 10. Have difficulty dealing with family stress such as illness,<br>death, or separation? | _____ | _____ |
| 11. Demand much individual adult attention?  | _____ | _____ |
| 12. Accept discipline and limits?  | _____ | _____ |

VII. Is there any other information that will help us understand this child?

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Has the child attended a preschool? \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_ no. of years  
Does your child know how to read? \_\_\_\_\_ Yes \_\_\_\_\_ No  
Does your child know how to write? \_\_\_\_\_ Yes \_\_\_\_\_ No

Would you like an individual conference with the staff social worker to relate any information you don't feel you can include in this form? \_\_\_\_\_

Thank you for your patience in filling out this questionnaire,

# Welcome to Holy Spirit Kindergarten

Child name: \_\_\_\_\_ Nickname \_\_\_\_\_

Address \_\_\_\_\_ Date of Birth \_\_\_\_\_

Child lives with \_\_\_\_\_ Phone No. \_\_\_\_\_

Fathers name \_\_\_\_\_ Mothers name \_\_\_\_\_

Place of employment(s) \_\_\_\_\_

Work Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Cell\Pager no. \_\_\_\_\_ Cell\Pager no. \_\_\_\_\_

Individual to reach in case of emergency \_\_\_\_\_ Phone \_\_\_\_\_

Previous daycare or preschool experience \_\_\_\_\_

What will be your child's transportation to school? \_\_\_\_\_

What will be your child's transportation from school? \_\_\_\_\_

Will your child be attending Holy Spirit after school care? \_\_\_\_\_

How does your child feel about starting kindergarten? \_\_\_\_\_

What do you hope your child will learn this year? \_\_\_\_\_

What are your child's strengths & interests? \_\_\_\_\_

Do you have any concerns we should know about, such as:

health concerns or allergies \_\_\_\_\_

learning or developmental problems \_\_\_\_\_

emotional concerns, such as fears and anxieties \_\_\_\_\_

How would you describe your child? \_\_\_\_\_

If there is anything else that would be helpful to know about your child before working with your child please indicate \_\_\_\_\_

Are you and your child Catholic? \_\_\_\_\_

If you are not Catholic, what is your religious affiliation? \_\_\_\_\_

Thank you for taking the time to provide us with the above information. It will help us a great deal in meeting the needs of your child. Please send it in with your child on the first day of school.

Sincerely,

Describe your child's preschool experience (positive, negative, separation issues, etc)

Child's name: \_\_\_\_\_

I\We, the parent(s)\guardian(s) of \_\_\_\_\_ request that the school, allow my\our son\daughter to participate in this fieldtrip. I\We hereby release and save harmless Holy Spirit Catholic School and any and all of its employees from any and all liability for any and all harm arising to my\our son\daughter as a result of this trip. I\We, the undersigned, have read this release and all its terms and execute it voluntarily and with full knowledge of its significance.

In the event of an emergency and we cannot be contacted. we hereby authorize that emergency treatment may be administered.

Parent\guardian signature: \_\_\_\_\_ Date: \_\_\_\_\_  
The following are special circumstances regarding my child of which you should be aware

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***This form is required by the school for your child to participate in field trips.***