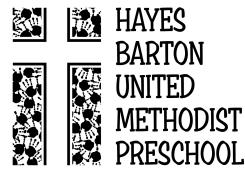
2s PARENT QUESTIONNAIRE

Dear Parents,

Please complete this questionnaire to help us provide your child with a smooth transition and preschool experience. Thank you!

CHILD'S NAME
DATE OF BIRTH
SIBLINGS (names/ages)
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PHYSICAL DEVELOPMENT

Please check under the word that best describes your child's ability in the following areas

	Good	Average	Needs help	Not applicable
Walks				
Runs				
Feeds self				
Uses a Sippy/ Straw Cup				
Sits in a chair				
Holds a coloring tool (ex: crayon)				

Do you have any concerns about your child's physical development? Yes	_ No
*If yes nlease explain:	

COMMUNICATION

Please check under the word that best describes your child's communication

	Good	Average	Needs help	Not applicable
Repeats words				
Uses words/phrases independently				
Is easily understood				

Do you have any concerns about your child's speech or communication? Yes No *If yes, please explain:
BEHAVIORAL/EMOTIONAL DEVELOPMENT:
Has your child ever separated from you before (ex: Church nursery)? Yes No If so, how does he/she respond to that separation?
Is your child splitting time between HBUMP and another preschool? Yes No Does your child have any special habits (thumb sucking, nail-biting)? Yes No *If yes, please explain:
Does your child have a special comfort item? Yes No
Any specific fears? Yes No
Can your child play independently and for how long? Yes No
Does your child become frustrated easily? Yes No* *If yes, please explain:
How does your child express frustration?
What makes your child angry, and how does she/he express anger?
What approach do you use to guide your child's behavior? How does he/she respond to it?
How does your child react to new situations?
Please list your child's favorite activities/interests:
What 3 words best describe your child?
How do you and your family spend time together?

SLEEPING HABITS Does your child still take a morning nap? Yes No My child usually naps ____ times/day from _____ to ____ My child usually sleeps at night from _____ p.m. to ____ a.m. Does your child have any sleep disturbances? Yes___ No___ Does your child sleep with any special object? Yes___ No___ Does your child remain in his/her crib at night? Yes___ No___ *Please explain: **EATING HABITS** Does your child have any food allergies/sensitivities? Yes No If so, has an HBUMP allergy plan been created? Yes No Does your child remain seated while eating? Yes___. No___ What foods does your child like?

TOILETING

*Please explain:

What foods does your child dislike?

Does your child feed himself/herself? Yes___ No___

Is your child fully potty trained? Yes____ No___

Does your child ask to go to the bathroom? Yes___. No___

Any eating challenges we should know about? Yes___ No___

SELF HELP SKILLS

Does your child like to help with jobs at home?

SPECIAL MEDICAL CONSIDERATION
Has the pediatrician ever expressed concern over your child's development? YesNo
Please list any family concerns, if applicable:
Does your child have any distinguishing birthmarks/skin conditions? YesNo
*If yes, please explain:
PARENT EXPECTATIONS
What are your goals and expectations for your child at Hayes Barton United Methodist Preschool
Do you have any special concerns or questions?
How would you like to participate in our program?
share a special skill/interest:
assist with classroom activities:
help make materials (playdoh, sensory bins)
join us for special events:
other:
Signature of Parent or Legal Guardian Date