Central A&M Pre-K & Kindergarten Screening Parent Questionnaire

***Please note that this information is required by the State of Illinois and will be kept confidential. It will be used to determine your child's eligibility for the prekindergarten program and give us a better picture of your child. Thank you for your time and cooperation.

Today's Date_____ Child's birthdate: _____

Child's full name: _____
Name child goes by:_____ ___Boy ___Girl
Address:_____ Town:_____
Phone:_____
Primary language: _____
One or both parents employed? _____father _____mother
Is this child/family homeless? ___yes ___no

Father's name:_____ age:___
Address if different from child's: _____
Home Phone: _____ Cell Phone: _____
Email: _____
Education: __High School Diploma __GED __College __other:_____
Place of employment: _____
Work hours: __day __night __swing shift

Mother's name:_____ age:_____
Address if different from child's:_____
Home Phone: _____ Cell Phone: _____
Email: _____
Education: __High School Diploma __GED ___College __other:_____
Place of employment: _____
Work hours: __day __night __swing shift

Please check which of the following best describes the child's family structure:

_____ Both parents in the home
_____ Single parent family (lives with ___mother ___father)
_____ Lives with an adult other than parent (guardian, grandparent, aunt, uncle, other_____)

_____Ward of the state/foster child
_____ Other: _____

List names of all people living in the household.

Name	Relationship	Age

Agencies and/or programs involved with the family:

__United Cerebral Palsy (UCP)
__DCFS
__County Health Dept.
__Head Start
__WIC
__SNAP
__Medicaid
__Free/Reduced school lunch
__Public Aid (IDPA)
__Illinois Dept. of Mental Health
__Prekindergarten
__Division of Services for Crippled Children
__TANF
__Child Care Subsidy
__Early Intervention services
__Macon Piatt Special Education- Date services began _____.
Other:_____

Do any of the following apply?

Check any of the following that may apply. Feel free to give more details to the right of any item checked to help us better understand how we may be of service to you and your family. Remember, this is kept confidential and used only to help support you and your family.

__History of child abuse/neglect (parent or child)
__History of abuse/domestic violence
__History of drug/alcohol abuse in the family
__Family member or child currently diagnosed with a chronic or terminal illness

__Family member or child currently diagnosed with a documented disability
__Family member currently or in past diagnosed with a mental illness
__Death of an immediate family member
__Family member active military
__Parent/guardian/caretaker incarcerated
__Excessive mobility (has moved more than three times since birth of this child)
__No phone in the child's home
__No vehicle in the child's home
__Family member currently with or in the past has been diagnosed with a learning disability or dyslexia
__Family member currently or in the past has been enrolled in Special Education
__Family member currently or in the past has been diagnosed with behavior disorder/ADD/ADHD
__Family member or child currently receiving counseling

Has anything happened which may be influencing your child's development? For example, death, separation, divorce, relocation, new baby, etc.
__yes, Please explain_____ __no

Please check the annual income level for your household (confidential information and will not be shared):
____ $0-9,999
____ $10,000-19,999
____ $20,000-29,999
____ $30,000-39,999
____ $40,000-49,999
____ $50,000-59,999
____ $60,000-69,999
____ $70,000-79,999
____ $80,000-89,999
____ $90,000-99,999
____$100,000+

Has your child attended any of the following?:

__Preschool School name: _____

How many years/months/days: _____

Days per week: _____ Hours per day: _____

__Childcare Experience Provider/center name: _____

How many years/months/days: _____

Days per week: _____ Hours per day: _____

__Other social experiences: _____

Family doctor:_____ Phone number:_____

Child's place of birth: City:_____ State:_____ Country:_____

Was your child premature?

__yes, How much? Please explain_____

__no

Child's birth weight:_____

Were there any complications or difficulties during pregnancy and birth of this child?

____yes, Please explain_____

____no

Check the items that apply to this child's pregnancy /delivery:

__Single birth __Multiple birth

__Prenatal exposure to drugs/alcohol __Failure to thrive

__Chronic or congenital illnesses, if so, please explain_____

__Disability, if so, explain_____

Age of the mother at the birth of first child: _____

Age of the father at the birth of first child: _____

Have there been any other injuries, accidents, or illnesses since birth?

____yes, Please explain_____

____no

Is this child healthy on the day of screening?

____yes

____no, Please explain_____

Is this child presently on medication?
____yes, please explain_____ ____no

Has this child had a vision or hearing test prior to today?
____yes, Please explain_____
____no

At what age did this child first begin to speak (approximately?)
First words_____ Two or more words together_____ Sentences_____

What age did this child start walking? _____

Toilet trained? __yes When?_____ ____no

Do you notice, or has your doctor reported, any of the following in this child?

__Asthma
__Indigestion
__Diarrhea
__Frequent fevers
__Headaches
__Epilepsy (seizures)
__Lack of consciousness
__Chronic ear infections (more than 2 per year)
__Difficulty hearing
__Nose bleeding
__Heart trouble
__Vomiting
__Sinus trouble
__Nightmares
__Difficulty seeing
__Difficulty sleeping
__Overtired/lack of energy
__Nail biting
__Constipation
__Stomach aches
__Allergies
__Thumb sucking
__Diabetes

Has your child ever attended Pre-kindergarten, Head Start, or a private school? __yes Where? _____ __no

Does your child seem to have difficulty:

__talking in complete sentences
__walking without tripping
__playing well with other children
__minding you (explain)
__separating from you (clings, cries)

Do you feel your child is:

__fearful
__worries a lot
__aggressive
__passive
__overly active or hyperactive
__immature
__acts older than age

Do you have concerns about your child's development?

_____

_____

_____

How would you describe your child's temperament?

_____

_____

Check all behavior that describes your child:

__becomes angry easily	__lying	__extremely shy/quiet
__temper tantrums	__teases others	__tense/nervous
__overactive	__fighting	__fearful
__stealing		

What does your child do that pleases you? _____

_____

How do you discipline your child? _____

_____

Are any of your other children having trouble in school? _____

_____

I give my permission for my child_____

(name)

to participate in the DIAL screening.

Parents signature:_____ Date_____

Signature of person giving information: _____

Date _____

_____

Relationship to child