

ROBERTA REINER
PRINCIPAL

January, 2012

Dear Parents,

If you have a child who will be five by November 30, 2012, please read on. Your child is eligible to begin kindergarten in September 2012. We request you register your child during kindergarten registration week in February. The purpose of registering at this time of year is to help us identify all the children in our district who may attend kindergarten in the fall. This supports our projection for the number of kindergarten classes. It also begins the process of introducing you to Pequenaconck. It does not obligate your child to attend.

If you would like to register your child:

Registration will take place at PQ during the week of February 6, 2012. Registration is Monday, February 6 through Friday, February 10 between the hours of 3:30 pm and 6:30 pm. It is not necessary to bring your child to school for registration.

Parents who are unable to come to school on the dates that are scheduled for registration should contact Mrs. Jean Jerussi at 914-669-5317 ext. 3056, so we may add your child to our plans. Please schedule another date to come in to register.

Registration is a 10 minute paperwork process and will be held in our Nurse's Office. Parents must bring all of the following in order to register; **we cannot register** your child if any of these are incomplete:

- a. a **copy** of your child's birth certificate or other proof of birth (passport, baptismal certificate);
- b. a **copy** of your child's record of immunizations, signed by your child's doctor;
- c. photo identification of parent registering the student (driver's license, etc.);
- d. proof of residence of parent (deed or mortgage statement with address of property; if renting, lease/rental agreement with proof of ownership of the landlord of the property); if you are already a registered family in the district you will just need proof of identity;
- e. proof of guardianship, if applicable
- f. all registration papers can be found on the Kindergarten Registration page of the school website, www.northsalemschools.org;

Children entering kindergarten are required to provide proof of receiving the following immunizations prior to the start of school:

- 3 doses of Diphtheria Toxoid Containing Vaccine;
- 3 doses of Tetanus Toxoid-Containing Vaccine and Pertussis Vaccine (if born after 1/1/05);
- 3 doses of polio vaccine;
- 2 doses of measles at least one as an MMR;
- 3 Hepatitis B vaccine;
- 1 Varicella vaccine (chicken pox);

Our school nurse will check the required immunization and health services paperwork. If immunization of your child is not complete by registration time, we will still register your child, but do require that the immunization records be up-to-date before the start of school in September. **If your child is not immunized by the opening of school, he/she will not start school.** A physical examination is also required and must not be more than twelve months prior to the start of the school year in which the examination is required or should be completed within 30 days of the start of school.

If you are unsure:

Sometimes at this point in the year a parent will be concerned as to whether or not their child is “ready” to come to school. If your child attends nursery school or daycare, please confer with the person who knows your child. If you feel hesitant about your child’s readiness and would like to talk with us at school in advance of the kindergarten screening, please contact me at 669-5317 ext. 3041. **Please plan to register your child, but tell us you are unsure. We also advise** you to register your child for nursery school so that your child will have a place should he or she not attend kindergarten.

We look forward to meeting you at PequenaKonck! Once you have registered, I will write to you about our plans for the spring; parent orientation, kindergarten student screening and our pre- kindergarten student visitation in June – bus ride and all! Most of our communication is through email so please don't forget to send Jean Jerussi your email address. You may email her at jerussij@northsaalem.k12.ny.us. Please do not hesitate to call if you have any questions now or along the way.

Sincerely,



Roberta Reiner
Principal

RR:jj

PEQUENAKONCK ELEMENTARY SCHOOL

173 JUNE ROAD • NORTH SALEM • NEW YORK • 10560-1202
914•669•5317 • FAX 914•669•4326 • WWW.NORTHSALEMSCHOOLS.ORG

NORTH SALEM CENTRAL SCHOOL DISTRICT STUDENT INFORMATION AND REGISTRATION FORM

Today's Date _____

Student's Last Name:	First Name:	Middle:
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Date of Birth:	Place of Birth:	Gender:
----------------	-----------------	---------

Present Grade Level:	Currently attending (please indicate name of school):
If student will be starting school in September, which grade did student just complete?	

If student is transferring from another school, has the "Release of Records" been completed and signed by the parent/guardian? <input type="checkbox"/> yes <input type="checkbox"/> no	Street Address:	
	City: State/Zip	
	Telephone #	Fax #

Has the student received any additional education services? If yes, please indicate:

<input type="checkbox"/> reading room	<input type="checkbox"/> speech therapy	<input type="checkbox"/> physical therapy
<input type="checkbox"/> math remediation	<input type="checkbox"/> occupational therapy	<input type="checkbox"/> language support
<input type="checkbox"/> special education program		
<input type="checkbox"/> social service agencies who support family or child:		
<input type="checkbox"/> other:		

Sibling Information – please include first and last names			
Name:	M/F	Date of Birth	Current School and Grade:

Has this family been previously registered in the North Salem Central School District? yes no

Student's Last Name:			First Name:		Middle:
Student's Residence Address: Street:			Student's mailing address, if different:		
City	State	Zip	City	State	Zip
Student's home telephone number: (please include area code)					
With whom is the student living? (check all that apply) <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Stepmother <input type="checkbox"/> Stepfather <input type="checkbox"/> Grandparent <input type="checkbox"/> Guardian <input type="checkbox"/> Other			If the parents are divorced, who has custody?		
			In addition to student's residence, to whom should mail be sent?		
Mother's Name:			US Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Mother's Residence Address Street:			Mother's Mailing Address, if different		
City State		Zip	City	State	Zip
Home Telephone	Cellular		E-mail address		
Highest Level of Education:			Occupation:		
Employer Name/Address			Employer Telephone		
Father's Name:			US Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Father's Residence Address Street:			Father's Mailing Address, if different		
City State		Zip	City	State	Zip
Home Telephone	Cellular		E-mail address		
Highest Level of Education:			Occupation:		
Employer Name/Address			Employer Telephone:		
Stepparent/Guardian Information Name Address City Telephone			Stepparent/Guardian Information Name Address City Telephone		

Parent/Guardian Signature _____ Date: _____

For Office Use Only:					
Intake by: _____	Proof of Birth: _____	Proof of Residency _____			
Health registration complete? _____	Immunization record: _____	Request for Release of Records: _____			
Medical Alert? _____	Legal Alert? _____	Student Residency Questionnaire _____			

NORTH SALEM CENTRAL SCHOOL DISTRICT
STUDENT HEALTH HISTORY AND REGISTRATION FORM
(To be completed by parent of a student who did not attend North Salem Central School District last year)

Student's Last Name:	First Name:	Middle:
Date of Birth:	Gender: Gra	de:

Please record approximate year child had any of the following:

Chicken Pox _____	Ulcers _____	Rheumatic Fever _____
Measles _____	Contact with Tuberculosis _____	Epilepsy _____
Mumps _____	Diabetes _____	Poliomyelitis _____
Whooping Cough _____	Major Fractures _____	High Blood Pressure _____
Heart Disease _____	Extended Illness _____	Ear Problems (tubes?) _____
Lyme Disease _____	Other: _____	

Please provide information about the entries selected above:

Has the child had any surgery, injuries or illnesses requiring hospitalization? No

Yes: please explain _____

Is there any allergy to drugs, foods or stinging insects? No

Yes: please explain _____

Does this child have asthma or hay fever? No

Yes: please explain and include medication information _____

Does this child experience convulsive episodes or fainting spells? No

Yes: please explain _____

Does this child wear glasses? No Yes

If *yes*, are glasses to be worn at all times? No Yes For reading only? No Yes For distance? No Yes

Is this student under treatment or taking medication for any condition at the present time? No

Yes: (please indicate the diagnosis and the name of the medication/dosage/frequency)

Is this student on medication that should be taken during school hours? No

Yes: please explain _____

Is there any other condition for which the Health Office should be made aware? No

Yes: please explain _____

Name of physician: _____ Telephone _____

Signature _____ Date : _____

Please use reverse for additional notes, and check here

Dear Parent/Guardian:

Beginning with the 2010-2011 school year, school districts and states are required to follow new standards in collecting and recording individual-level race and ethnicity data in accordance with the federal categories and definitions. The information will be used to:

- Report information to the State and Federal Education Departments
- Plan educational programs and make sure that they are readily available to all students
- Do statistical analysis

We need your help in order to accomplish this task. Please review the Racial/Ethnic definitions on the Student Racial and Ethnic Identification on the reverse side of this page and complete the form for each of your children who will be enrolled in the North Salem Central School.

There are TWO areas that are needed to be checked off on the form.

- ✓ First, check YES or NO regarding whether or not the child is of Hispanic, Latino or Spanish origin.
- ✓ Second, check ONE OR MORE of the following choices that are true about the child's ethnicity/race. For example, you would check Asian *and* White for a child that was Asian and White.

North Salem Central School District understands the sensitive nature of this information and wishes to assure you that it will be kept secure and confidential in accordance with all State and Federal student privacy laws and regulations. If we are unable to get this information from you then, according to State and Federal regulations, we are required to use our own judgment to identify the race and ethnicity of the child. The form may not be blank.

Thank you for your cooperation. If you have any questions, please call your school's principal.

CONFIDENTIALITY PROCEDURES AND REGULATIONS

To the Parent/Guardian:

The information which you have provided on this form is confidential. It is protected by the Confidentiality Regulations cited below.

The Family Educational Rights and Privacy Act (1974) and Regulations of the Chancellor A-820 prohibits unauthorized access to student records and unauthorized release of any student record information identifiable by either student name or student identification number

**PLEASE COMPLETE THE FORM ON THE
REVERSE SIDE OF THIS PAGE**

- All students between 5 and 21 years of age have the right to a free public education
- Children may not be refused admission to a public school because of race, color, creed, national origin, gender, gender identity, pregnancy, immigration/citizenship status, disability, sexual orientation, religion, or ethnicity.

Name of School:	
Student Identification Number:	Date of Birth (Month/Day/Year):
Student Name: Last, First, Middle:	Grade Level:

DIRECTIONS TO PARENT/GUARDIAN

PLEASE ANSWER BOTH QUESTIONS (1) AND (2). PLEASE READ THEM CAREFULLY BEFORE YOU RESPOND.

<p>1. Is the student Hispanic, Latino, or of Spanish origin? Hispanic, Latino, or of Spanish origin means a person of Cuban, Mexican, Puerto Rican, Central or South American, or other Spanish culture or origin, regardless of race [Check (√) <u>one</u> that best describes your child].</p> <p style="text-align: center;"> <input type="checkbox"/> YES, Hispanic <input type="checkbox"/> NO, not Hispanic </p>
<p>2. Check (√) one or more races from the following five racial groups [Check (√) all groups that apply to your child; check (√) <u>at least ONE</u> box.]:</p> <p><input type="checkbox"/> AMERICAN INDIAN OR ALASKAN NATIVE: A person having origins in any of the original peoples of North and South America (including Central America) and who maintains tribal affiliation or community attachment. E.g. Cherokee, Mohawk, Inuit.</p> <p><input type="checkbox"/> ASIAN: A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent. Including for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand and Vietnam.</p> <p><input type="checkbox"/> NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER: A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or Other Pacific Islands.</p> <p><input type="checkbox"/> BLACK: A person having origins in any of the Black racial groups of Africa.</p> <p><input type="checkbox"/> WHITE: A person having origins in any of the original peoples of Europe, North Africa, or the Middle East.</p>

Signature of Parent/Guardian/Other

Date

Relationship to Student:

- Mother
 Father
 Guardian
 Other (Specify) _____

See reverse side for important message to Parent/Guardians and Confidentiality Procedures and Regulations.

NORTH SALEM CENTRAL SCHOOL DISTRICT STUDENT RESIDENCY QUESTIONNAIRE

In compliance with the McKinney-Vento Homeless Education Assistance Act and New York Education Law, every school district is required by the State Education Department's Title I Office to have all new registrants, and all students who change addresses complete a residency questionnaire.

Name of School _____

Name of Student _____ Sex: Male
Last *First* *Middle* Female

Birth Date ____/____/____ Age: ____ Social Security #: _____
Month *Day* *Year* *(or student identification number)*

The answer you give below will help the district determine what services you or your child may be able to receive under the McKinney-Vento Act. Students who are protected under the McKinney-Vento Act are entitled to immediate enrollment in school even if they don't have the documents normally needed, such as proof of residency, school records, immunization records, or birth certificate.

1. Is your current address a temporary living arrangement? ____ Yes ____ No
2. Is this temporary living arrangement due to loss of housing or economic hardship? ____ Yes ____ No

**If you answered YES to the above questions, please complete the remainder of this form.
If you answered NO, you may stop here.**

Where is the student currently living? (Check one box)

- In a motel/hotel
- In a shelter
- With another family or other person because of loss of housing or as a result of economic hardship
- In a car, park, bus, train or campsite
- Other temporary living situation (Please describe): _____

Print Name of Parent, Guardian, or
Student (for unaccompanied homeless youth)

Date

Signature of Parent, Guardian, or
Student (for unaccompanied homeless youth)

Please send a copy to Mary Jo Hauser, Homeless Liaison at the Central Office. (Fax: 914-669-8753)

OFFICE USE ONLY

I certify the above named student qualifies for the Child Nutrition Program under the provisions of the McKinney-Vento Act.

Date

McKinney-Vento Liaison Signature



Home Language Questionnaire (HLQ)

TO BE COMPLETED BY SCHOOL PERSONNEL

DISTRICT _____ *Please print or type clearly*

SCHOOL _____ GRADE _____

STUDENT NAME _____

DATE OF BIRTH _____
Month: _____ Day: _____ Year: _____

STUDENT IDENTIFICATION NUMBER _____

COUNTRY OF BIRTH / ANCESTRY _____

NUMBER OF YEARS ENROLLED IN SCHOOL OUTSIDE THE U.S. _____

NAME/POSITION OF SCHOOL PERSONNEL COMPLETING THIS SECTION _____

DETERMINATION: Possible LEP
 English Proficient

Dear Parent or Guardian:

In order to provide your child with the best possible education, we need to determine how well he or she understands, speaks, reads and writes English. Your assistance in answering these questions is greatly appreciated.

Thank You

(✓ boxes that apply)

- What language(s) is spoken in the student's home or residence? English Other _____ *specify*
- What language(s) are spoken most of the time to the student, in the home or residence? English Other _____ *specify*
- What language(s) does the student understand? English Other _____ *specify*
- What language(s) does the student speak? English Other _____ *specify*
- What language(s) does the student read? English Other _____ Does Not Read *specify*
- What language(s) does the student write? English Other _____ Does Not Write *specify*
- In your opinion, how well does the student understand, speak, read and write English?

	<i>Very well</i>	<i>Only a little</i>	<i>Not at all</i>
Understands English	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Speaks English	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reads English	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Writes English	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Signature of Parent/Guardian/Other

Date

Month: _____ Day: _____ Year: _____



CUESTIONARIO SOBRE EL IDIOMA QUE SE HABLA EN EL HOGAR ("Home Language Questionnaire, HLQ") – Spanish

*Estimado Padre/Madre o Guardián:
Para poder ofrecer a su hijo(a) la mejor educación posible, necesitamos determinar cuán efectivamente él o ella entiende, habla, lee y escribe el idioma inglés. Su ayuda será apreciada si contesta estas preguntas.*

Gracias.

PARA SER COMPLETADO POR EL PERSONAL ESCOLAR (TO BE COMPLETED BY SCHOOL PERSONNEL)

DISTRITO (District)	IMPRIMA O ESCRIBA CLARAMENTE (Please print or type Clearly)		
ESCUELA (School)	GRADO (Grade)		
NOMBRE DEL ESTUDIANTE (Student Name)			
FECHA DE NACIMIENTO (Date Of Birth)			
Mes: (Month)	Día: (Day)	Año: (Year)	
NUMERO DE IDENTIFICACION DEL ESTUDIANTE (Student Identification Number)			
PAIS NATAL O ASCENDENCIA (Country of Birth/Ancestry)			
NUMERO DE AÑOS MATRICULADO EN ESCUELA(S) FUERA DE LOS E.U. (Number of years enrolled in school outside the U.S.)			
NOMBRE/POSICIÓN DEL PERSONAL ESCOLAR LLENANDO ESTA SECCION (Name/Position School Personnel Completing This Section)			
DETERMINACIÓN: (Determination)			
		<input type="checkbox"/> Posiblemente LEP (Possibly LEP)	
		<input type="checkbox"/> Dominante en Inglés (English Proficient)	

(✓ Marque las casillas que aplican)

- ¿Qué idioma(s) se habla en el hogar o residencia del estudiante? Inglés Español Otro _____
(Especifique cuál)
- ¿En qué idioma(s) se le habla al estudiante la mayor parte del tiempo en el hogar o residencia? Inglés Español Otro _____
(Especifique cuál)
- ¿Qué idioma(s) entiende el estudiante? Inglés Español Otro _____
(Especifique cuál)
- ¿Qué idioma(s) habla el estudiante? Inglés Español Otro _____
(Especifique cuál)
- ¿En qué idioma(s) lee el estudiante? Inglés Español Otro _____ No lee
(Qué idioma)
- ¿En qué idioma(s) escribe el estudiante? Inglés Español Otro _____ No escribe
(Qué idioma)
- ¿En su opinión, qué tan bien el estudiante entiende, habla, lee y escribe inglés?

	Muy bien	Un poco	Nada
Entiende Inglés	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Habla Inglés	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lee Inglés	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Escribe Inglés	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

HEALTH CERTIFICATE / APPRAISAL FORM

Rec'd _____
Appr _____

Name: _____ Date of Birth: _____

School: _____ Gender: M F Grade: _____

IMMUNIZATIONS / HEALTH HISTORY

<input type="checkbox"/> Immunization record attached <input type="checkbox"/> No immunizations given today <input type="checkbox"/> Immunizations given since last Health Appraisal: Dental _____	Sickle Cell Screen: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not done Date: _____ PPD: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not done Date: _____ Elevated Lead: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not done Date: _____ Referral <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not done Date: _____
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Significant Medical/Surgical History: See attached _____

Allergies: LIFE THREATENING Food: _____ Insect: _____ Other: _____
 Seasonal Medication: _____

PHYSICAL EXAM

Height: _____ Weight: _____ Blood Pressure/Pulse: _____ Date of Exam: _____
Referral

Body Mass Index: _____ Weight Status Category (BMI Percentile): <input type="checkbox"/> less than 5 th <input type="checkbox"/> 5 th through 49 th <input type="checkbox"/> 50 th through 84 th <input type="checkbox"/> 85 th through 94 th <input type="checkbox"/> 95 th through 98 th <input type="checkbox"/> 99 th and higher	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="border: none;">Vision - without glasses/contact lenses</td> <td style="border: none;">R</td> <td style="border: none;">L</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;">Vision - with glasses/contact lenses</td> <td style="border: none;">R</td> <td style="border: none;">L</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;">Vision - Near Point</td> <td style="border: none;">R</td> <td style="border: none;">L</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;">Hearing <input type="checkbox"/> Pass 20 db sc both ears or:</td> <td style="border: none;">R</td> <td style="border: none;">L</td> <td style="border: none;"></td> </tr> </table>	Vision - without glasses/contact lenses	R	L		Vision - with glasses/contact lenses	R	L		Vision - Near Point	R	L		Hearing <input type="checkbox"/> Pass 20 db sc both ears or:	R	L	
Vision - without glasses/contact lenses	R	L															
Vision - with glasses/contact lenses	R	L															
Vision - Near Point	R	L															
Hearing <input type="checkbox"/> Pass 20 db sc both ears or:	R	L															

EXAM ENTIRELY NORMAL Tanner: I. II. III. IV. V. Scoliosis: Negative Positive: _____

Specify any abnormality (use reverse of form if needed): _____

MEDICATIONS

Medications (list all): None Additional medications listed on reverse of form

Name: _____ Dosage/Time: _____

Name: _____ Dosage/Time: _____

If AM dose is missed at home: _____

I assess this student to be self-directed Yes No Student may self carry and self administer medication Yes No
 Note: Nurse will also assess self-direction for the school setting. Please advise parent to send in additional medication in the event that emergency sheltering is necessary at school or if the morning medication has not been given.

PHYSICAL EDUCATION / SPORTS / PLAYGROUND / WORK QUALIFICATION / CSE CONSIDERATION

Free from contagions & physically qualified for all physical education, sports, playground, work & school activities OR only as checked:

___ Limited contact: cheerlead, gymnastics, ski, volleyball, cross-country, handball, fence, baseball, floor hockey, softball.
 ___ Non-contact: badminton, bowl, golf, swim, table tennis, tennis, archery, riflery, weight train, crew, dance, track, run, walk, rope jump.

Specify medical accommodations needed for school: _____ None

Known or suspected disability: _____ Please monitor

Restrictions: _____ Please monitor

Protective equipment required: Athletic Cup Sport goggles/impact resistant eyewear Other: _____

OPTIONAL INFORMATION, if known

Specify current diseases: Asthma Diabetes: Type 1 Type 2 Hyperlipidemia Hypertension
 Other: _____

Provider's Signature: _____ Phone: _____ (Stamp below)

Provider's Name/Address: _____ Fax: _____

Parent Signature: _____ Date: _____

North Salem Central School District Immunization Record

Student's Name _____

Date of Birth _____

	Date	Date	Date	Date	Date
Polio (IPV or OPV)					
Diphtheria (DTaP/DTP/DT/TD)					
Tetanus, Diphtheria and Pertussis Booster (Tdap)					
Measles, Mumps and Rubella (MMR)					
Hepatitis B					
HiB					
PCV					
Varicella					
TB Test					
Menactra					

Doctor's Signature _____

Date _____

KINDERGARTEN STUDENT INFORMATION SHEET

In order to gain a greater understanding of your child, we appreciate your completion of this sheet. If you have any concerns about a question or would like to talk to us in person, please let us know. Thank you.

CHILD'S FULL NAME: _____ BIRTHDATE: _____

FAMILY HISTORY: Name of Siblings Sex Age Grade Academic Adjustment

Other people living in your home: _____

BIRTH AND EARLY CHILDHOOD HISTORY:

Full Term: _____ Birth Weight: _____ Mother's Health at time of birth: _____

Delivery: Induced _____ Special circumstances (loss of oxygen, jaundice, prematurely, incubation, respiratory distress, early eating problems, cesarean section, additional comments: _____

Approximate age of sitting alone: _____ Walking: _____ Talking: _____

Speech development (underline): Stuttering, baby talk, lispings, can't think of words, faulty enunciation, loses thought, delayed, normal: other: _____

Any unusual occurrence in child's early life (underline and explain): Accident, fire, hospitalization, moving, separation from parent, death or illness of close family member, lived in a foreign country, other: _____

What language, other than English does your child speak or understand? _____

Does your child have any specific fears? Unusual eating habits or patterns, or problems with control, trouble separating from parents (baby-sitters, etc.), sleep problems; please explain: _____

MEDICAL HISTORY

Any major or chronic illnesses: (history of ear infections, allergies, convulsions, pneumonia?) _____

Accidents: (stitches, etc.) _____

Hospitalization: (include age of child, length of stay, reason for stay) _____

When your child is upset, in what way(s) might he/she respond or behave? _____

General Health: _____ Wears glasses? _____ Hearing loss? _____

over please....

KINDERGARTEN STUDENT INFORMATION SHEET

Did your child attend nursery school: _____ Where: _____
How long? _____

How did your child adjust to Nursery School? _____

Does your child enjoy being alone: _____ Does your child play with others: _____
How frequently? _____
Does he/she prefer same age _____, older, _____ or younger children _____.
Does he/she share: ____ How does he/she settle differences of opinion with playmates? _____

How many hours daily does your child watch TV? _____

How does your child react in new situations? _____

Is your child shy with adults? _____

Do you feel your child is advanced, at age level, or needs growth in these areas?

Language Development: _____

Creative and Imaginative Play: _____

Athletic Skills: _____

Social Interaction: _____

Academic Skills, Reading Readiness: _____

Math: _____

Printing: _____

Artistic - Musical Ability: _____

Does your child read? Please explain (books/words): _____

Has your child had any special testing or received any special help or intervention? Please explain: _____

Does your child have any special interest or take special lessons or attend special classes?
(Gymnastics, music, etc.) _____

Is there anything further you'd like us to know about your child? _____

Thank you for helping us get to know your child. We look forward to getting to know you both!

Roberta Reiner and Dennis Tandler
Principal School Psychologist

Person completing this form

Date