



Parent Questionnaire 2020 - 2021 School Year

Child's Full Name: _____ D.O.B. ___/___/___

Name Child is Called: _____ Gender: M ___ F ___

Names and Ages of Siblings: _____

Is your child going to the bathroom on his/her own? _____

What descriptive words would you use to describe your child? _____

What are some of your child's favorite activities or special interests? _____

How does your child usually react to new situations? _____

Has your child experienced being separated from you for a short period of time? If so, how did your child react? _____

Does your child have any known allergies or dietary restrictions? _____

Does your child have any developmental concerns, health problems, special needs or taking medication we should be aware of? _____

Do you have any special concerns or something important you think we should know about your child? _____

What are your hopes/goals for your child's preschool experience? _____
