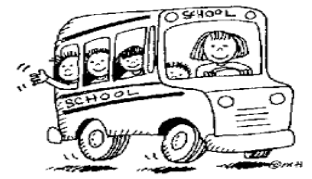




Derry Township School District

Administrative Office • 30A East Granada Avenue • P.O. Box 898 • Hershey, PA 17033
Phone (717) 534-2501 • Fax (717) 533-4357 • www.hershey.k12.pa.us



DTSD Kindergarten Profile/Questionnaire

Please help our school learn as much as we can about your child so that his/her kindergarten year can be a very successful one!
We look forward to working with you and your child.

Child's LAST Name	Child's FIRST Name	Child's Date of Birth	Child's Gender (Please check one)	
			<input type="checkbox"/>	MALE
			<input type="checkbox"/>	FEMALE

How would you like your child's name to be labeled in the classroom? (This is the name we will call your child.):

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Mother's FULL Name		Mother's Phone		Mother's Address			
First		Home:					
Last		Work:					
Father's FULL Name		Father's Phone		Father's Address			
First		Home:					
Last		Work:					
Student Lives with: (Please check one)		<input type="checkbox"/>	Mother	<input type="checkbox"/>	Father	<input type="checkbox"/>	BOTH

Language Spoken First by Child	Language Child Uses Most Often	Language Parents Use Most Often	Do you have concerns about your child's understanding of English? (Please check one)	
			<input type="checkbox"/>	YES
			<input type="checkbox"/>	NO

Please list your child's siblings and their ages:

1. Name		Age		3. Name		Age	
2. Name		Age		4. Name		Age	

Please list family cultural or related information that we should know (including food items your child cannot eat):

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Technology – (Please check one answer for each question.)				
1. Do you have Wi-Fi at home?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
2. Do you have a printer at home?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
3. Does your child have a device (iPad, tablet, etc.)?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
4. If you answered yes for #3, please list the type of device:	<input type="text"/>			

My child has participated in these activities (check all that apply):

<input type="checkbox"/>	Preschool	<input type="checkbox"/>	In-Home Child Care	<input type="checkbox"/>	Daycare
<input type="checkbox"/>	Organized Sports	<input type="checkbox"/>	Play Group	<input type="checkbox"/>	Creative/Dramatic Activities (dance, music, arts & crafts...)

Please name preschool/daycare:

List the dates your child attended preschool/daycare:

List the daily length of time spent in preschool/daycare

Did your child have an IEP or any special help or services at preschool/daycare? (If so, please describe and also submit a copy of your child's IEP to DTSD if applicable):

What observations did the preschool/daycare share with you about your child? (Please submit a copy of your child's most recent progress report with DTSD if applicable.)

My child enjoys these activities (check up to 5):

<input type="checkbox"/>	Looking at books	<input type="checkbox"/>	Using computer / technology	<input type="checkbox"/>	Playing with puzzle/blocks	<input type="checkbox"/>	Watching TV
<input type="checkbox"/>	Art projects/coloring	<input type="checkbox"/>	Imaginative play	<input type="checkbox"/>	Listening to stories	<input type="checkbox"/>	Playing outside

My child is excited about learning: Often Sometimes Not yet

My child plays well with other children: Often Sometimes Not yet

My child enjoys playing alone: Often Sometimes Prefers playing with others

My child is respectful: Often Sometimes Not Yet

My child is cooperative/follows directions: Often Sometimes Not yet

My child stays interested in self-chosen activities (not including any kind of screen time) for:		15+ minutes		5-15 minutes		Less than 5 minutes
My child stays on task to complete activities assigned to him/her for:		15+ minutes or until completed		5-15 minutes or until completed		Less than 5 minutes or does not complete
My child work/plays without bothering others and can change behavior when requested of him/her:		Often		Sometimes		Not yet
My child is able to dress him/herself (zippers, buttons, snaps, ..) independently:		Often		Sometimes		Not yet
My child is fully toilet trained and takes care of toileting needs independently:		Often		Sometimes		Not yet
My child will ask for help when needed:		Often		Sometimes		Not yet
My child separates easily from parent:		Often		Sometimes		Not yet
Someone reads to my child:		Often		Sometimes		Rarely
Please list your child's strengths:		Please list some things your child is still working on/weaknesses:				
Please describe your child in 3 words:		The year in kindergarten, I would like for my child to...				
What should your child's teacher know about him/her?						

MEDICAL INFORMATION

Are there any significant delays in developmental milestones? (walking, talking, etc.)		YES		NO
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Please explain:

Please list below any medical concerns for your child (i.e., asthma, seizures, chronic respiratory conditions, chronic GI conditions, feeding issues, impaired mobility &/or activity restrictions/limitations, etc.

Please list below any severe allergies (i.e., food, bee sting, etc.) Does your child have an Epi-pen for emergency use?

Do you think your child has difficulty hearing or seeing?		YES		NO
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Was your child born prematurely?		YES		NO
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Teacher and Transportation requests should be submitted under separate cover.