Bienvenue aux écoles francophones

Conseil scolaire Centre-Nord

In order to help us better know your child and his or her needs, we ask that you fill out this questionnaire. If you have questions, please do not hesitate to contact us.

Thank you for your help and support!

Date :_____

Name of the child : _____

Date of birth : _____

Country of birth : _____

Conseil scolaire Centre-Nord

FAMILY INFORMATION

1. Mother's name : _____ occupation : _____

2. Father's name : _____ occupation : _____

3. How is your family constituted? both parents ☐ single parent☐

blended ☐ other ☐ _____

4. Does the child live with : mother ☐ father ☐ both ☐ other : _____

5. Is there a joint custody? yes ☐ no ☐

6. If so, please tell us about the conditions:

_____

7. How is the parent who spends less time with the child planning on being involved in the child's school life?_____

_____

8. Who has the legal custody of the child? _____

9. Who are the other people living with the child ? (brother, sister, other adult)

Name Age Relationship to child

_____

_____

_____

LANGUAGE AND COGNITIVE DEVELOPMENT

1. What language(s) are spoken at home?

1st _____ 2nd _____ 3rd _____

2. What language(s) does your child speak?

1st _____ 2nd _____ 3rd _____

3. What is the mother's first language? _____ the father?_____

4. How well can your child express himself(herself) in French?

Very well ☐ Well ☐ A little ☐ Not at all ☐

5. Can your child understand directions in French?

Very well ☐ Well ☐ A little ☐ Not at all ☐

6. Does your child have difficulties expressing himself (herself) in English or French? (e.g. difficulties with pronunciations)

Very often ☐ Often ☐ Sometimes ☐ Never ☐

7. If so, have you consulted a health specialist regarding some of the difficulties?

yes ☐ no ☐ If so, which specialist(s) : _____

8. Does your child like to sing, recite nursery rhymes or imitate commercials heard on TV or radio?

Very often ☐ Often ☐ Sometimes ☐ Never ☐

9. Does your child like to hear stories?

A lot ☐ Somewhat ☐ A little ☐ Not really ☐

10. What is your child doing when he or she is focused and on task?

_____

_____

HEALTH AND PHYSICAL DEVELOPMENT

1. Does your child have or has ever had any of the follwing problems : (please check all that apply)

Ear infection	☐	Vision problem	☐	Ear ache	☐	Hearing problem	☐
asthma	☐	allergies	☐	epilepsy	☐	Severe allergies (anaphylaxies)	☐

Other information :

_____

2. Does your child take any medication? If so, which ones?

_____

_____

3. Were there complications during birth? If so, which ones?

_____

_____

4. Fine motor skills

- Does your child like to draw?

  A lot ☐ Somewhat ☐ A little ☐ Not really ☐

- Is your child able to dress himself (herself) without help? yes ☐ no ☐
- Is your child able to button his (her) jacket? yes ☐ no ☐
- Is your child able to do up his(her) zipper? yes ☐ no ☐

5. Gross motor skills
   - Does your child like to run and jump?

     A lot ☐ Somewhat ☐ A little ☐ Not really ☐

   - Does your child like walking?

     A lot ☐ Somewhat ☐ A little ☐ Not really ☐

   - Is your child able to go up and down the stairs one foot at a time?

     yes ☐ no ☐

6. Is your child able to go to the bathroom on his (her) own? yes ☐ no ☐

   Does he (she) have accidents? often ☐ sometimes ☐ never ☐

7. Sleeping habits (please check all that apply)

Agitated sleep	☐	Deep sleep	☐	Speaks while asleep	☐
Is afraid of the dark	☐	Snores	☐	Wets the bed	☐
Remembers dreams	☐	Night terrors	☐	Stops breathing	☐
Has nightmares	☐				

- Does your child sleep alone? yes ☐ no ☐
- Generally, during the week, your child gets up at _____ and goes to bed at _____. On the weekend, your child gets up at _____ and goes to bed at _____ .
- Normally, how long does it take your child to fall asleep? _____
- Do you read with him (her) before bedtime as part of your routine?

  yes ☐ no ☐

- When your child gets up, does he (she) generally feel well? yes ☐ no ☐
- Does your child fall asleep easily in a car? yes ☐ no ☐

8. Is your child generally tired after a physical activity? yes ☐ no ☐

If so, how does he (she) show it?

_____

9. What are your child's eating habits?

_____

_____

SOCIOAFFECTIVE DEVELOPMENT

Please circle all that apply to your child

1. When your child is at his (her) best, which qualifiers describe his (her) behaviour?

sensitive, nervous, timid, has tantrums, active, calm, dependent, independent, cuddly, aggressive, sociable, loner, communicative, reserved, other_____

2. How doe your child behave with other children?

timid, cuddly, aggressive, loner, nice, persuasive, cooperative, independent, passive, destructive, has tantrums, impulsive, calm, communicative, reserved, other_____

3. Does your child participate in group activities?

Playschool, preschool, sport, dance, ABC Headstart, other(s)_____

in French ☐ and/or in English ☐

4. Ordinarily, how does your child behave with adults?

Shows respect, friendly, timid, interested, confident, collaborative, pleasant,communicative, reserved, other_____

5. How does your child feel about starting kindergarten?

happy, worried, scared, indifferent, anxious, nervous, can't wait, other_____

6. How do you discipline your child if he (she) does not listen?

_____

_____

7. How does your child react when this happens?

_____

_____

8. Are there things or events that upset your child?

Fear of the dark, fear of animals, parental separation, noise, other

_____

9. Which activities does your child like best?

blocks, puzzles, toys, music, television, computer, video games, sports outdoor activities, other _____ Prefers to be ***alone in room, always close to you,*** _____

10. What may be some areas that concern you in your child's development?

_____

_____

11. What are his (her) strengths or areas that come easily to him (her)?

_____

_____

12. How do you feel about your child entering kindergarten?

_____

_____

_____

13. Do you have other comments regarding your child that would help us to know him (her) better?

_____

_____

Present at the meeting :

child ☐	mother ☐	father ☐	guardian ☐
others :			

Thank you!