

**THREE VILLAGE CENTRAL SCHOOL DISTRICT**  
Setauket, New York

**KINDERGARTEN SOCIAL DEVELOPMENT HISTORY**

Dear Parents:

In order to help ensure a successful initial school experience for your child, it is important to know something of your child's development and preschool experiences and any special concerns or considerations you may feel are important to share. Please complete the following and return it at your child's kindergarten registration.

**Family Data**

Child's name: \_\_\_\_\_ Birth date: \_\_\_\_\_ Age: \_\_\_\_\_

Home address: \_\_\_\_\_ Home phone: \_\_\_\_\_

Parent Name: \_\_\_\_\_ Age: \_\_\_\_ Education: \_\_\_\_\_

Employment: \_\_\_\_\_ Phone: \_\_\_\_\_

Parent Name: \_\_\_\_\_ Age: \_\_\_\_ Education: \_\_\_\_\_

Employment: \_\_\_\_\_ Phone: \_\_\_\_\_

Child lives with: mother, father, stepfather, stepmother (circle all that apply)

Stepparent's Name: \_\_\_\_\_ Age: \_\_\_\_ Education: \_\_\_\_\_

Employment: \_\_\_\_\_ Phone: \_\_\_\_\_

Stepparent's name: \_\_\_\_\_ Age: \_\_\_\_ Education: \_\_\_\_\_

Employment: \_\_\_\_\_ Phone: \_\_\_\_\_

If parents are divorced, please indicate who has custody of the child:

\_\_\_\_\_

Custody Instructions:

Custodial Parent Name \_\_\_\_\_ Phone# \_\_\_\_\_

Court Documentation YES / NO

**Children living inside the home:**

Name, grade, age and school: \_\_\_\_\_

Name, grade, age and school: \_\_\_\_\_

Name, grade, age and school: \_\_\_\_\_

Name, grade, age and school: \_\_\_\_\_

**Other children living outside the home:**

Name and age: \_\_\_\_\_

Name and age: \_\_\_\_\_

Other persons living in the home: \_\_\_\_\_

Check if child is: Foster child \_\_\_\_\_ Adopted \_\_\_\_\_ Age when placed: \_\_\_\_\_

**Birth and Infancy**

**A. Prenatal and Birth:**

1. Mother's general health during pregnancy: \_\_\_\_\_

2. Labor and delivery: Normal \_\_\_\_\_ Complications \_\_\_\_\_

3. Specify any complications during pregnancy, labor and/or delivery: \_\_\_\_\_  
\_\_\_\_\_

4. Birth weight: \_\_\_\_\_ 5. Infant's days in hospital: \_\_\_\_\_

**B. Infancy:**

1. Check one:            **Early**            **Average**            **Later than peers**

Age of sitting	_____	_____	_____
Age of crawling	_____	_____	_____
Age of walking	_____	_____	_____
Using single words	_____	_____	_____
Using sentences	_____	_____	_____
Toilet training	_____	_____	_____

2. Please specify any concerns regarding your child's development:  
\_\_\_\_\_  
\_\_\_\_\_

**Health History**

1. Has your child had any serious illnesses, accidents, operations or hospitalizations?

Yes \_\_\_\_ No \_\_\_\_ If so, please describe: \_\_\_\_\_  
\_\_\_\_\_

2. Is your child taking medication on a regular basis? Yes \_\_\_\_ No \_\_\_\_\_

If so, please describe: \_\_\_\_\_

3. Please check any particular health problems your child has:

- |   |  |                                       |
|---|--|---------------------------------------|
| <input type="checkbox"/> Allergies                    | <input type="checkbox"/> Asthma        | <input type="checkbox"/> Earaches     |
| <input type="checkbox"/> Faulty elimination           | <input type="checkbox"/> Headaches     | <input type="checkbox"/> Nosebleeds   |
| <input type="checkbox"/> Repeated colds               | <input type="checkbox"/> Sinus trouble | <input type="checkbox"/> Stomachaches |
| <input type="checkbox"/> Other, please describe _____ |  |                                       |

### Speech and Language History

1. Can you understand your child's speech?  
All/most of the time \_\_\_\_ Some of the time \_\_\_\_ Little of the time \_\_\_\_\_

2. Can others understand your child's speech?  
All/most of the time \_\_\_\_ Some of the time \_\_\_\_ Little of the time \_\_\_\_\_

3. What is the primary language spoken in your home? \_\_\_\_\_

4. Are any other languages spoken in your home? Yes \_\_\_\_ No \_\_\_\_\_

If so, please list: \_\_\_\_\_

5. Uses language effectively to communicate with peers, adults? Yes \_\_\_\_ No \_\_\_\_\_

6. Maintains eye contact during conversation? Yes \_\_\_\_ No \_\_\_\_\_

### Hearing and Vision History

1. Has your child's hearing ever been checked? Yes \_\_\_\_ No \_\_\_\_\_

If so, where? \_\_\_\_\_ Date of last exam: \_\_\_\_\_

Results: \_\_\_\_\_

2. Do you have any concerns regarding your child's hearing? Yes \_\_\_\_ No \_\_\_\_\_

If so, please describe \_\_\_\_\_

3. Has your child had a lot of ear infections? Yes \_\_\_\_ No \_\_\_\_ At what ages? \_\_\_\_\_

4. Has your child's vision ever been checked? Yes \_\_\_\_ No \_\_\_\_\_

If so, where? \_\_\_\_\_ Date of last exam: \_\_\_\_\_

Results: \_\_\_\_\_

5. Do you have any concerns regarding your child's vision? Yes \_\_\_\_ No \_\_\_\_\_

If so, please describe: \_\_\_\_\_

6. Does your child have listening or attentional problems (e.g., easily distracted short attention span, darts from one activity to another)? Yes \_\_\_\_ No \_\_\_\_\_

If so, please describe:  
\_\_\_\_\_

### General Information

1. How many different places has your child lived? \_\_\_\_\_

2. Has your child attended preschool? Yes \_\_\_\_ No \_\_\_\_\_  
If so, where and when \_\_\_\_\_

How did your child respond to this experience?  
\_\_\_\_\_

3. Are there any illnesses or special circumstances in the home which affect your child?

Yes \_\_\_\_ No \_\_\_\_ If so, please describe

4. Have there been any changes in your child's life that may have been stressful or upsetting?

Yes \_\_\_\_ No \_\_\_\_ If so, please describe \_\_\_\_\_

5. Does your child have any nervous habits or special fears? Yes \_\_\_\_ No \_\_\_\_\_  
If so, please describe \_\_\_\_\_

6. Do you feel your child is shy? Yes \_\_\_\_ No \_\_\_\_\_

7. Has your child received any educational support services (e.g., special education/  
OT/PT/speech/language)? Yes \_\_\_\_ No \_\_\_\_  
If so, please describe \_\_\_\_\_

8. What are your child's favorite activities and interests? \_\_\_\_\_  
\_\_\_\_\_

9. What does your child do that causes him/her to be disciplined most often? \_\_\_\_\_  
\_\_\_\_\_

10. What is the most effective discipline for your child? \_\_\_\_\_  
\_\_\_\_\_

11. Compared with other children his/her age, how well does your child:

	<b><u>Not As Well</u></b>	<b><u>About the Same</u></b>	<b><u>Better</u></b>
Get along with siblings?	_____	_____	_____
Get along with friends?	_____	_____	_____
Play alone?	_____	_____	_____
Play with others?	_____	_____	_____

12. What is your child's attitude toward starting school?  
\_\_\_\_\_

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13. Please check any areas of concern you have about your child:

- |                                       |   |   |
|---------------------------------------|---|---|
| <input type="checkbox"/> Eating       | <input type="checkbox"/> Getting along with adults          | <input type="checkbox"/> Bed-wetting                      |
| <input type="checkbox"/> Fears        | <input type="checkbox"/> Uses baby talk                     | <input type="checkbox"/> Nightmares                       |
| <input type="checkbox"/> Sulking      | <input type="checkbox"/> Nervous habits                     | <input type="checkbox"/> Whining                          |
| <input type="checkbox"/> Speech       | <input type="checkbox"/> Wants to be babied                 | <input type="checkbox"/> Nail biting                      |
| <input type="checkbox"/> Coordination | <input type="checkbox"/> Doesn't sleep alone                | <input type="checkbox"/> Destructive                      |
| <input type="checkbox"/> Daydreaming  | <input type="checkbox"/> Temper tantrums                    | <input type="checkbox"/> Cries easily                     |
| <input type="checkbox"/> Fighting     | <input type="checkbox"/> Restless sleeping                  | <input type="checkbox"/> Overly neat                      |
| <input type="checkbox"/> Teasing      | <input type="checkbox"/> Complains of being sick            | <input type="checkbox"/> Separation difficulty            |
| <input type="checkbox"/> Jealousy     | <input type="checkbox"/> Getting along with other children  | <input type="checkbox"/> Shy in new situations            |
| <input type="checkbox"/> Disobedience | <input type="checkbox"/> Lack of concern for other children | <input type="checkbox"/> Reaction to birth of<br>siblings |

14. Please note anything else you think may be helpful in making your child's school experience successful:

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**Name of person completing form:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Relationship to child:**

If questionnaire was completed by an interviewer, please sign below:

**Interviewer:** \_\_\_\_\_ **Date:** \_\_\_\_\_