

Student Name: _____ Date of Birth: _____

Guardian #1 First and Last Name: _____ Email: _____

Guardian #2 First and Last Name: _____ Email: _____

Kindergarten Meet the Teacher Appointment Time Preference: (plan for 90 minutes)

August 24th, 25th or 28th morning/afternoon

Morning (range 8:30-11:30)

Afternoon (range 12:00-3:00)

No Preference

Please indicate your child's early childhood experience:

<input type="checkbox"/> Preschool Name: _____	<input type="checkbox"/> Day Care Name: _____	<input type="checkbox"/> Other: Name: _____
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Does your child have a medical diagnosis that may impact him at school: (epilepsy, ADHD, etc.) _____

Has your child ever been evaluated to qualify for early intervention services from the school district? If yes, please explain. _____

Does your child need additional support/services in the following areas:

<input type="checkbox"/> Speech (example: child's speech is hard to understand by unfamiliar listeners)	<input type="checkbox"/> English Learning (example: child speaks more than one language)
<input type="checkbox"/> Fine Motor (example: child needs adult support to write name or cut with scissors)	<input type="checkbox"/> Gross Motor (example: child needs help running, walking, climbing)
<input type="checkbox"/> Hearing	<input type="checkbox"/> Vision
<input type="checkbox"/> None of these apply to my child	<input type="checkbox"/> Other

Does your child need to take medicine while at school: Yes No

Does your child have allergies: Yes No

Does your child need a classroom placement in our allergy classroom? Yes No

Please select all that apply regarding your **child's behavior**: : None of these apply to my child

<input type="checkbox"/> Separation Anxiety (example: child frequently cries when dropped off at school)
<input type="checkbox"/> Refusal: (example. Child consistently does not follow adult instructions)
<input type="checkbox"/> Attention: (example: child has a hard time focusing on a learning task)
<input type="checkbox"/> Agression: (example: child shows anger by hitting others or throwing things)
<input type="checkbox"/> None of these apply to my child

When you show your child uppercase letters (out of order) they can:

<input type="checkbox"/> Name 20-26 uppercase letters	<input type="checkbox"/> Name 10-19 uppercase letters	<input type="checkbox"/> Name less than 10 uppercase letters
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When you show your child lowercase letters (out of order) they can:

<input type="checkbox"/> Name 20-26 lowercase letters	<input type="checkbox"/> Name 10-19 lowercase letters	<input type="checkbox"/> Name less than 10 lowercase letters
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When you show your child numbers from 1-10 (out of order) they can:

<input type="checkbox"/> Name 8-10 numbers	<input type="checkbox"/> Name 5-7 numbers	<input type="checkbox"/> Name 0-4 numbers
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When your child counts they can:

<input type="checkbox"/> Counts to 20 or higher	<input type="checkbox"/> Counts to 10	<input type="checkbox"/> Miscounts or skips numbers when counting or counts to a number less than 10
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Please share any other information that would be helpful to us in determining the best learning environment for your child.
