



Maleny State School Parent Questionnaire

Child's Name:		Date of Birth: __/__/__
Mother's Name:		
Father's Name		
Is your child the <input type="checkbox"/> youngest <input type="checkbox"/> eldest <input type="checkbox"/> middle child in your family?		
Who are the people your child lives with?		
Have there been any recent changes in your family – new house/baby/marriage/divorce/death?		
How will your child arrive at and leave School? <input type="checkbox"/> car <input type="checkbox"/> bus <input type="checkbox"/> walk <input type="checkbox"/> bike		
Physical development		
Was your child born at full term? <input type="checkbox"/> Yes <input type="checkbox"/> No If premature, how early?		
Did your child have a <input type="checkbox"/> normal or <input type="checkbox"/> difficult birth?		
At what age did your child crawl?	Walk?	
Has your child had any serious illnesses, operations or accidents? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Do you have any concerns about your child's development? Please give details		
Eyesight <input type="checkbox"/> Yes <input type="checkbox"/> No	Hearing <input type="checkbox"/> Yes <input type="checkbox"/> No	
Speech <input type="checkbox"/> Yes <input type="checkbox"/> No	Physical Coordination <input type="checkbox"/> Yes <input type="checkbox"/> No	
Does your child have any allergies? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Language Development		
If not English, what is the main language spoken at home?		
At what age did your child start to talk?		
How well does your child listen and follow instructions?		
Social/Emotional Development		
How do you think your child will react to starting a new school?		
Does your child like to play alone or with others		

How does your child react to change, new challenges, frustration and failure?
Do you have any concerns about your child's social/emotional development?
Home activities
What are your Child's favourite toys, games, books, DVD's, TV programs at the moment?
What activities does your child enjoy doing?
<div>Watch TV</div> <div>Use a computer</div> <div>Read</div> <div>Draw/Colour in</div> <div>Participate in physical activity outside?</div>
Cultural Considerations
Does your child require any special considerations for:
<input type="checkbox"/> Food <input type="checkbox"/> Clothing <input type="checkbox"/> Celebrations <input type="checkbox"/> Sports Activities
Specialists Services: Has your child been seen by a:
<input type="checkbox"/> Speech & Language Pathologist
<input type="checkbox"/> Occupational Therapist
<input type="checkbox"/> Physiotherapist
<input type="checkbox"/> Paediatrician
<input type="checkbox"/> Optometrist
<input type="checkbox"/> Audiologist
<input type="checkbox"/> Other Specialist
<input type="checkbox"/> Has your child received Learning Support in the past?
How does your child perform academically?
<div>Maths</div> <div>English</div>
What are your child's main strengths?
Other information concerning your child we should know.....
Thank you for taking the time to fill out the questionnaire.