

## Maleny State School Prep 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?	
• Are both parents Emergency Contacts?	
• Are both parents to receive Correspondence?	
• Have there been any recent changes in your family – new house / baby / marriage / divorce / death?	
<b><i>Physical development</i></b>	
• Was your child born at full term? <input type="checkbox"/> Yes <input type="checkbox"/> No If premature, how early?	
• Did your child have a normal/difficult birth? <input type="checkbox"/> Yes <input type="checkbox"/> No	
• At what age did your child crawl?	Walk?
• Has your child had any serious illnesses, operations or accidents? <input type="checkbox"/> No <input type="checkbox"/> Yes,	
• Does your child still have a daytime rest/sleep? <input type="checkbox"/> Yes <input type="checkbox"/> No	
• Can your child toilet themselves? <input type="checkbox"/> Yes <input type="checkbox"/> No	
• Do you have any concerns about your child's development? Please give details.	
<b>Eyesight</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Hearing</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Speech</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Physical Coordination</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
<b><i>Language Development</i></b>	
• At what age did your child start to talk?	
• If not English, what is the main language spoken at home? If so what % is it spoken at home?	
• How well does your child listen and follow instructions?	
<b><i>Social/Emotional Development</i></b>	
• How does your child react when you leave them in someone else's care?	

<ul style="list-style-type: none"> <li>• How do you think your child will react to starting Prep?</li> </ul>
<ul style="list-style-type: none"> <li>• What opportunities has your child had to socialize with other children their own age? Did they attend: <input type="checkbox"/> Day Care <input type="checkbox"/> Family Day Care <input type="checkbox"/> Kindergarten <input type="checkbox"/> Playgroup <input type="checkbox"/> Other</li> <li>• How often did they attend?</li> </ul>
<ul style="list-style-type: none"> <li>• Does your child like to play alone or with others?</li> </ul>
<ul style="list-style-type: none"> <li>• How does your child react to change, new challenges, frustration and failure?</li> </ul>
<ul style="list-style-type: none"> <li>• Do you have any concerns about your child's social/emotional development?</li> </ul>
<p><b>Home activities</b></p>
<ul style="list-style-type: none"> <li>• What are your child's favourite interests / toys, games, books, or TV. programs at the moment? This helps us to communicate on an individual basis with your child.</li> </ul>
<p><b>Cultural Considerations</b></p>
<ul style="list-style-type: none"> <li>• Does your child require any special considerations for: <ul style="list-style-type: none"> <li><input type="checkbox"/> Food <input type="checkbox"/> Clothing</li> <li><input type="checkbox"/> Celebrations <input type="checkbox"/> Sports Activities</li> </ul> </li> </ul> <p><b>Please explain:</b></p>
<p><b>Specialist Services:</b> Has your child been seen by a:</p>
<ul style="list-style-type: none"> <li>○ <b>Speech &amp; Language Pathologist?</b> <input type="checkbox"/>Yes <input type="checkbox"/>No</li> </ul>
<ul style="list-style-type: none"> <li>○ <b>Occupational Therapist?</b> <input type="checkbox"/>Yes <input type="checkbox"/>No</li> </ul>
<ul style="list-style-type: none"> <li>○ <b>Physiotherapist?</b> <input type="checkbox"/>Yes <input type="checkbox"/>No</li> </ul>
<ul style="list-style-type: none"> <li>○ <b>Paediatrician?</b> <input type="checkbox"/>Yes <input type="checkbox"/>No</li> </ul>
<ul style="list-style-type: none"> <li>○ <b>Optometrist?</b> <input type="checkbox"/>Yes <input type="checkbox"/>No</li> </ul>
<ul style="list-style-type: none"> <li>○ <b>Audiologist?</b> <input type="checkbox"/>Yes <input type="checkbox"/>No</li> </ul>
<ul style="list-style-type: none"> <li>○ <b>Other Specialist?</b> <input type="checkbox"/>No <input type="checkbox"/>Yes Details:</li> </ul>
<p><b>Please provide the school with any Dr Reports of any know Diagnosis of your child.</b></p>
<ul style="list-style-type: none"> <li>• <b>What are your expectations of Prep?</b></li> </ul>

Thank you for taking the time to fill out the questionnaire. 😊