BERGENFIELD PUBLIC SCHOOL DISTRICT
KINDERGARTEN
Developmental Information

A. **GENERAL INFORMATION – Please Print**

____ ______________________ Male _____ Female _____

Student's **Last Name** / **First Name** Birth Date (Mo/Day/Yr)

____

Language Spoken at Home

Has your child attended nursery or preschool? Yes or No

If Yes, the Name & Address of school: ____

Number of years attended? _______ Days per week: ___________________

Were there any issues or concerns at the nursery/preschool? ____

____

Hand Preference: Right _____ Left _____ Uses Both Equally _____

B. **BIRTH HISTORY:** Was the baby full term? _______ Premature? ________ Birth weight __________

Did the baby need oxygen?_______ Did the baby stay longer than the mother in hospital?_______

If yes, why? ____

Any other issues during delivery? ____

Circle those problems the baby may have experienced: *jaundice, convulsions, deformities, respiratory difficulties, feeding difficulties, i.e., swallowing, colic, vomiting, diarrhea, abnormal crying.*

C. **DEVELOPMENTAL HISTORY (PAST/PRESENT):** Did your child attend an Infant Stimulation Center?

_____ If so, which one? ____

Has your child demonstrated any problems in the following areas? If so, please explain:

Language/Speech ____

Vision ____

Hearing ____

Sitting ____

Crawling ____

Standing ____

Walking ____

Toilet Training________________ Bladder Control ____________ Bowel Control ____________

Does your child wear diapers?__________ During the day?________ During the night? ________

D. **SOCIAL/EMOTIONAL:** Place a check on the line between the closest words which best describe your child:

Happy	1	2	3	4	5	6	Sad
Outgoing	1	2	3	4	5	6	Shy
Easy Going	1	2	3	4	5	6	Nervous
Separates easily *(from parent/guardian)*	1	2	3	4	5	6	Does not separate easily *(from parent/guardian)*
Plays well with others	1	2	3	4	5	6	Plays alone

Has your child ever experienced an upsetting emotional shock? (auto accident, death, divorce, or other situation) ______________ If so, please explain:

____

____

Is your child's attention span usually very short? Does he/she jump from one task to another without being able to pay attention to any one thing for long? (Please describe)

____

____

Does your child engage in self-stimulating behaviors like spinning, rocking, hand flapping, twirling objects, etc? (Please describe)

____

____

Does your child have temper tantrums? _____ If yes, when does this happen and what causes them?

____

Does your child get frustrated easily? ____

Does your child still take a nap? ____

When does he/she go to bed at night? _____ When does he/she wake up? ______

How does your child react when you leave him/her with a baby-sitter, at a nursery or preschool?

____

E. **ADDITIONAL CONSIDERATIONS:** What do you see as your child's strengths?

____

Is there any additional information that you feel would be helpful in planning for your child's school year?

____

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If there is any change of the above information, kindly inform the Principal. If there are any other concerns that you wish to share with us, please contact any of the staff (teacher, principal, school nurse, therapist, or psychologist) at the school in which your child may attend. Thank you for your cooperation in completing this form. It will help make your child's school experience a more fulfilling one.