Prep Enrolment Questionnaire

Corinda State School

Please take the time to complete this questionnaire.

Information will help the Prep teachers transition your child into school.

You will need to bring this form with you to your child's Prep interview

Childs Name: _____

Preferred Name: _____

Date of birth: _____

Names and ages of siblings in the family: _____

Who will be bringing your child to Prep?

Name: _____ Relationship to child: _____

Will your child be attending Before or After School Care: yes/no

Which days (if applicable): Monday, Tuesday, Wednesday, Thursday, Friday

Will your child be attending Drop off Zone: yes/no

Which days (if applicable): Monday, Tuesday, Wednesday, Thursday, Friday

Is your child currently attending any of the following *(please tick and indicate how many days per week)*

- ☐ Day care Centre _____ Days per week
- ☐ Day care Centre (Kindergarten approved) _____ Days per week
- ☐ Family Day Care _____ Days per week
- ☐ C & K Kindergarten _____ Days per week
- ☐ Other (family or friends) _____ Days per week

Name of Centre your child is attending: _____

Does your child have any friends enrolling at Corinda from this centre or another:

_____

Are there any custody orders in place? Yes/no (if so who is the primary carer? _____)

Is another language other than English spoken at home? _____if yes, can your child speak the language? Yes/no

Is there any information on your family's cultural background, eating regimes, and religious beliefs etc we need to consider _____

_____

Has your child been immunised? Yes/no

Developmental milestones

Walking ☐ before 12 months ☐ 12 -18 months ☐ 18 -2 Years

Talking ☐ before 12 months ☐ 12 -18 months ☐ 18 -2 Years

How would you describe your child's personality?

☐ Happy ☐ Shy ☐ Out going

☐ Easy going ☐ Sociable ☐ Anxious

☐ Other _____

Does your child have trouble with any of the following:

☐ Eating/food allergies _____

☐ Medical conditions e.g. asthma, anaphylaxis _____

☐ Special needs _____

☐ Sleep _____

☐ Hearing _____

☐ Vision _____

☐ Toileting _____

☐ Speech language _____

☐ Movement _____

☐ Behaviour _____

☐ Seperation _____

Has your child received any support in any of the following areas:

	No	Yes (what age)	Length of support	Further details
Vision				
Hearing				
Speech language pathology				
Physiotherapy				
Occupational Therapy				

Please tick the most appropriate response that you think best describes your child:

	Yes	Sometimes	No
Writes own name			
Contributes to conversations – talks to children and adults			
Asks for help when needed			
Beginning to control feelings of anger/frustrations			
Takes turns in a game			
Co-operates with adults and follows rules			
Enjoys playing with others			
Cares for own belongings			
Is able to work alone at an activity for up to 10 minutes			
Repeats rhymes, songs or dances			
Enjoys drawing			
Engages in books and stories			

What do you consider your child's strengths?

_____

_____

What are your child's interests and preferred activities?

_____

_____

Do you have any concerns about your child?

_____

_____

Has there been any recent family changes that may affect your child? E.g. new baby, moved house, absence of parent, family illness?

_____

_____

Additional information (If required)

_____

_____

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