

PREP ENROLMENT QUESTIONNAIRE

Please take the time to complete this questionnaire to assist us in meeting your child's educational needs in the best possible way. Additional note space has been provided on the last page if there is insufficient space in some questions.

Child's Name: _____ Preferred Name: _____ D.O.B: _____

1. Names and ages of siblings in the family: _____

2. What arrangements have you made for bringing and collecting your child from Prep? By whom? _____

Classroom drop off/pick up

Front gate drop off/pick up

Catching Bus to /from

Other: _____

3. Any information on family changes recently? i.e. just moved house, absence of parent, family illness etc

4. Is your child in non-parental care on a regular basis? Y/N

If yes, is the care - full time (at least six hours a day, 5 days a week)

- part time (less than six hours a day, or not every day)

5. What type of care facility -

Day Care Centre - Name of Centre _____

Family Day Care Pre-Prep

Grandparent/other relative Kindergarten

Nanny Other (including friends or neighbours)



6. What do you see as the value of the preparatory year for your child?

7. Do any areas of your child's development concern you? (eg late milestones, difficult pregnancy or birth, fears, security toys or habits, eg thumb sucking, blanket)

8. Please note any difficulties with:

Sleep patterns _____

Movement _____

Speech language _____

Hearing/Vision _____

Toileting _____

Behaviour _____

Hospitalisation/Operations _____



9. MILESTONES

Walking-

Before 12 months

12 months to 18 months

18 months to 2 years

Talking

Before 18 months

18 months to 2 $\frac{1}{2}$ years

2 $\frac{1}{2}$ to 3 years

After 3 years

10. Has your child been immunized? Y/N

11. Does your child have a day time sleep? Y/N

If yes how long? _____

12. Has your child had any support/intervention in any of the following areas:

Eyes and Hearing Check

No

Yes : at what age _____

for how long _____

Speech Language Pathology

No

Yes : at what age _____

for how long _____

Occupational Therapy

No

Yes : at what age _____

for how long _____

Physiotherapy

No

Yes : at what age _____

for how long _____

Development Assessment Team

No

Yes : at what age _____

or how long _____

Other: _____

What assistance has been provided for any of the above difficulties? _____

13. Does your child have a diagnosis of:

Autism Spectrum Disorder

Hearing Impairment

Intellectual Impairment

Speech Language Impairment

Vision Impairment

Physical Impairment

14. Does your child have any medical conditions, special diet, specific food allergies or intolerances? **See EQ Standardised Medical condition Category List (attached). Please ensure medical details are completed on the enrolment form if any of the stated conditions apply to your child.**

15. Academic Development

Recognises their name

Yes

No

Can count to 10

Yes

No

Names some colours

Yes

No

Holds a book the right way up

Yes

No

Can use scissors independently

Yes

No

Recognises and names some letters

Yes

No

Writes their name

Yes

No



16. Social/Emotional Development

| | | |
|--|------------------------------|-----------------------------|
| Asks for help when having difficulty | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Contributes to adult conversation | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Repeats rhymes, songs or dances | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Is able to work alone at an activity for up to 10 minutes | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Will apologise without a reminder | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Takes turns in a game | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Shares toys and games | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Responds well to simple adult requests | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Follows rules in an adult led activity | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Beginning to control feelings and emotions | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Greets familiar adults without reminders | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Organises personal belongings | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Increasingly says "please" and 'thank you' without reminders | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Engages in socially acceptable behaviour in public | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Stays in own garden/playground area | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Plays near and talks with other children | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Often prefers to play with others | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Manages a lunch box and can eat independently | Yes <input type="checkbox"/> | No <input type="checkbox"/> |



17. In your opinion, what are your child's strengths/what does your child do well?

18. List area of play / learning that your child is interested in:

19. Does your child participate in any out of school activities eg soccer, pottery, drama, dance music, swimming?

20. Is there any information on your family's cultural background, languages other than English spoken at home, religious beliefs etc we need to consider in the program?

Other notes (if insufficient space was provided):

Thank you for taking the time to complete this questionnaire.

