Developmental Skills

Child's Name: _____

Please choose the response that best fits your child.

	No exposure to this skill.	Regularly working on this skill.	Able to independently complete this skill.
Writes name in lowercase letters.			
Cuts with scissors.			
Correctly counts 4-10 objects in a set.			
Shows interests in reading books by looking at the pictures.			
Recognizes name in print.			
Dresses independently.			

Social Skills Development

Please choose the response that best fits your child.

	Never	Sometimes	Always
Identifies likes and dislikes.			
Identifies personal feelings.			
Recognizes other's feelings.			
Accepts making mistakes without becoming upset.			
Identifies/explains problems with others.			

Medical Information

Do you notice or has your doctor reported any of the following:

- ☐ Asthma
- ☐ Heart Trouble
- ☐ Allergies
- ☐ Epilepsy
- ☐ Headaches
- ☐ Nosebleeds
- ☐ Sinus Trouble

Other: _____

What is your child's first language?

_____

Does your child speak so that others can understand?

Yes or No

Does your child have responsibilities at home?

Yes or No

Has your child had the opportunity to play with other children?

_____

Is your child left or right handed?

_____

Student After School Pick Up Information

- ☐ Parent/family vehicle pick up
- ☐ Parent/family walking pick up
- ☐ Bus
- ☐ Other: (ie: private day care, friend)
- ☐ Stonewall Children's Centre
- ☐ Starting Blocks

_____

If there is anything else you would like to share to help us get to know you child, feel free to use the space below.