

Kenosha Unified School District No. 1  
**KINDERGARTEN SCREENING INFORMATION FORM**

\*\* This form will be placed in your child's permanent school folder. All information will be considered confidential. \*\*

Student's Name \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ Gender: Male <sup>(Circle One)</sup> Female

Telephone: \_\_\_\_\_ Handedness: Right Left

Person completing this form: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

Language(s) spoken in the home: \_\_\_\_\_

Who does this child live with? (Include parents, brothers, sisters, and others.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please check the appropriate answer in each item listed below and explain when necessary.

**1. Health History**

Yes No

- Problems during pregnancy – If yes, please explain \_\_\_\_\_
- Problems during birth - If yes, please explain \_\_\_\_\_
- Premature birth
- Low birth weight
- Serious illness or accidents since birth – If yes, please explain \_\_\_\_\_
- Other health problems in infancy – If yes, please explain \_\_\_\_\_
- Any ongoing health problems – If yes, please explain \_\_\_\_\_
- History of ear infections
- Hearing problems
- Glasses
- Vision problems
- History of high lead levels
- Current high lead levels
- Child is presently taking prescribed medication. If yes, indicate the name of and reason for the prescription.  
\_\_\_\_\_
- Physical limitations - If yes, please explain \_\_\_\_\_
- Any special concerns expressed by a doctor – If yes, please explain \_\_\_\_\_

**2. Developmental History**

	Early	Average	Late
Learned to crawl	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Learned to walk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Learned to talk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you have seen a doctor or other professional person about problems or delays in speech or physical development, please explain.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**3. Family History**

Is there a history of learning problems or delays with immediate family members? (Please explain.)

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**4. Pre-kindergarten Learning/Group Experiences**

Yes No

- Head Start
- KUSD Early Childhood Special Education Program
- KUSD Early Childhood Peer Program
- Speech Impact Program
- 4-Year-Old Kindergarten

Yes No

- Preschool/Nursery school
- Day Care
- Library
- Sunday School
- Other (i.e lessons—music/art, athletics, etc)  
If yes, please specify.

Do you feel that any of the activities that your child participated in were especially positive or negative experiences? (Please explain)

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**5. Social/Emotional**

Please describe any recent major life changes (for example moving, divorce, serious illness or death in the family, etc.) your child has experienced.

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**6. Learning Readiness**

A. Please list your child's:

Strengths	Weaknesses	Special Interests

B. How does your child feel about starting kindergarten?

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C. Do you feel he/she is ready? \_\_\_\_\_

D. How easily does your child learn or pick up new things such as letters, words, colors, etc.

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**7. Do you have any significant concerns for your child in the following areas?**

- | Yes                      | No                       |  |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty using the bathroom independently          |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty in following instructions or instructions |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty in getting along with peers               |
| <input type="checkbox"/> | <input type="checkbox"/> | Inability to share materials                         |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty controlling temper                        |
| <input type="checkbox"/> | <input type="checkbox"/> | Cannot work or play independently                    |
| <input type="checkbox"/> | <input type="checkbox"/> | Is easily frustrated                                 |
| <input type="checkbox"/> | <input type="checkbox"/> | Short attention span                                 |
| <input type="checkbox"/> | <input type="checkbox"/> | Honesty  |
| <input type="checkbox"/> | <input type="checkbox"/> | Hits others  |
| <input type="checkbox"/> | <input type="checkbox"/> | Separation from parents                              |
| <input type="checkbox"/> | <input type="checkbox"/> | Fears – If yes, please explain.                      |

If you would like to talk with someone about any concerns, please contact your child's school principal.