

GEHLEN CATHOLIC SCHOOL

Parent Questionnaire

Date: _____

Child's Name: _____

Child's Date of Birth: _____ Place of Birth: _____

Parent's Name: _____

Address: _____

Home Phone: _____ Cell Phone: _____

Directions: Read the following statements and circle either "Yes" or "No".

- | | | |
|-----|----|---|
| Yes | No | 1. My child has attended preschool and/or Headstart. |
| Yes | No | 2. My child gets along well with other children. |
| Yes | No | 3. My child can be away from me for at least a half day without becoming upset. |
| Yes | No | 4. I have taken my child to the public library. |
| Yes | No | 5. My child has books of his/her own. |
| Yes | No | 6. My child can take care of his/her own toilet needs. |
| Yes | No | 7. My child can dress himself/herself. |
| Yes | No | 8. My child can name most of the parts of his/her body. |
| Yes | No | 9. My child can enter into a new activity without fear. |
| Yes | No | 10. My child can listen quietly while a teacher reads a story. |
| Yes | No | 11. My child can take care of his/her belongings. |
| Yes | No | 12. My child will likely be able to complete tasks without help from the teacher. |
| Yes | No | 13. My child wants to start school. |