

**OAKLAND PUBLIC SCHOOLS  
OAKLAND, NEW JERSEY**

**PARENT QUESTIONNAIRE**

Date \_\_\_\_\_  
Name of Child \_\_\_\_\_  
Date of Birth \_\_\_\_\_  
Sex        M \_\_\_\_\_        F \_\_\_\_\_

List names and ages of brothers and sisters:

Brothers:

Sisters:


With whom has the child been living for most of the past year?

Father \_\_\_\_\_        Mother \_\_\_\_\_        Both \_\_\_\_\_        Other \_\_\_\_\_

Language(s) other than English regularly spoken at home:

\_\_\_\_\_

\_\_\_\_\_

**School History** (Include preschool, day care, nursery school, etc.):

Has your child attended school before?        Yes \_\_\_\_\_        No \_\_\_\_\_

If so, how long?    6 mos. \_\_\_\_\_    1 Year \_\_\_\_\_    2 Years \_\_\_\_\_    3 Years \_\_\_\_\_

Name of school(s) attended:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Birth Information:**

Was your child premature? \_\_\_\_\_

What was your baby's birth weight? \_\_\_\_\_

Was oxygen required for the baby? \_\_\_\_\_

List any difficulties experienced during delivery: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Child's Health** (The following questions pertain to your child at any time since birth):

Has your child ever had any trouble seeing? \_\_\_\_\_

Have your child's eyes ever looked crossed? \_\_\_\_\_

Has your child ever had frequent ear infections? \_\_\_\_\_

Has your child ever had trouble hearing? \_\_\_\_\_

Is your child affected by allergies? \_\_\_\_\_ If "yes", which one(s)? \_\_\_\_\_

Has your child ever had fainting or blackout spells? \_\_\_\_\_

..... frequent headaches? \_\_\_\_\_

..... dizzy spells? \_\_\_\_\_

Has your child ever been hospitalized? \_\_\_\_\_

If so, for what? \_\_\_\_\_

At about what age did your child first:

sit alone? \_\_\_\_\_ walk? \_\_\_\_\_ become toilet trained? \_\_\_\_\_

say single words? \_\_\_\_\_ say sentences? \_\_\_\_\_

Does your child have any unusual health conditions? \_\_\_\_\_

If so, please describe: \_\_\_\_\_

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**Child Development:**

Can your child:

..... use a spoon and fork to eat without excessive spilling? \_\_\_\_\_

..... wash and dry his/her own hands? \_\_\_\_\_

..... dress himself or herself? \_\_\_\_\_

..... do buttons? \_\_\_\_\_

..... be left alone with a baby-sitter without a big fuss? \_\_\_\_\_

..... zipper clothing \_\_\_\_\_

Does your child have:

..... problems with eating? \_\_\_\_\_

..... problems with sleeping? \_\_\_\_\_

..... problems with toilet training? \_\_\_\_\_

Does your child:

..... play successfully with puzzles, blocks, and other construction toys without help? \_\_\_\_\_

..... hold a pencil properly? \_\_\_\_\_

..... write and draw rather than scribble? \_\_\_\_\_

..... prefer right hand? \_\_\_\_\_

..... left hand? \_\_\_\_\_

..... both? \_\_\_\_\_

Can your child:

..... ride a tricycle? \_\_\_\_\_

..... throw and catch a ball? \_\_\_\_\_

Does your child:

..... have many accidents? \_\_\_\_\_

..... drop things more often than other children the same age? \_\_\_\_\_

..... trip easily? \_\_\_\_\_

..... run into things? \_\_\_\_\_

..... have trouble with stairs? \_\_\_\_\_

How would you rate your child's activity level?

\_\_\_\_\_ highly active      \_\_\_\_\_ active      \_\_\_\_\_ quiet      \_\_\_\_\_ very quiet

Does your child:

..... often have temper tantrums? \_\_\_\_\_  
..... usually follow directions? \_\_\_\_\_  
..... have a short attention span? \_\_\_\_\_

Has your child had any trouble learning? \_\_\_\_\_

Is your child:

..... able to say most sounds correctly? \_\_\_\_\_  
..... afraid to speak? \_\_\_\_\_  
..... understandable to a stranger? \_\_\_\_\_

Did your child experience any delayed speech patterns? \_\_\_\_\_

Does your child have any speech problems that you are aware of? \_\_\_\_\_

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

Thank you for assisting us in getting to know more about your child. This information will help us to know your child better and to provide him or her with the most appropriate educational program.