Fox Valley Christian Academy
Kindergarten Developmental Survey

Child's name____ Birth date _______________
(Month/date/year)

1. At what age did your child walk alone? ____

2. At what age was your child completely toilet trained? ____

3. Does your child wet or soil himself/herself during the day? ____

4. Does your child do the following?

   Dress himself/herself? ☐ Completely ☐ Partially
   Button clothing? ☐ Yes ☐ No
   Tie shoes? ☐ Yes ☐ No

5. What hand does your child eat with? ☐ Right ☐ Left
   What hand does your child write or draw with? ☐ Right ☐ Left
   What hand does your child throw a ball with? ☐ Right ☐ Left

6. Does your child have any fears? ☐ Yes ☐ No If yes, please explain. ____________________________

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7. Does your child enjoy books and being read to? ☐ Yes ☐ No

8. What are his/her favorite activities at home? ____

   ____

9. How does your child spend his/her time? (Playing games, TV, computer, stories, outdoor activities, etc.)

   ____

   ____

10. Indicate items which your child uses at home: ☐ crayons ☐ pencils ☐ paints ☐ scissors ☐ blocks

    ☐ coloring books ☐ others ____

11. What type of discipline do you administer when your child disobeys? _________________________________

    ____

12. How does your child react to discipline? ____

    ____

13. How does your child respond to authority figures other than parents? _______________________________

    ____

14. Does your child anger easily? ☐ Yes ☐ No

    When your child becomes angry, how does he/she express anger? ___________________________________

    ____

15. When does your child become frustrated? ____

    ____

    ____

16. How does your child respond to new situations or changes in routine? _________________________________

    ____

    ____

17. Is your child shy in front of a group or around new people? ☐ Yes ☐ No

18. How does your child handle separation from you? ____

    ____

    ____

PHYSICAL INFORMATION

Please check all that apply.

- ☐ Premature birth
- ☐ Trauma at birth
- ☐ Chronic past or present ear infections
- ☐ Currently has tubes ☐ Left ☐ Right
- ☐ Asthma
  Describe treatment used. ____
- ☐ Allergies
  Please specify. ____
- ☐ Frequent headaches
- ☐ Chronic illness
- ☐ Visual concerns
  Please specify. ____
- ☐ Wears eyeglasses
- ☐ Hearing concerns
  Please specify.____
- ☐ Wears assistive hearing device

☐ Speech difficulties
Has your child received speech intervention? ☐ Yes ☐ No

☐ Does your child routinely take any medications? ☐ Yes ☐ No
If yes, please specify medication(s) and reason for taking.

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Please share any other concerns that could impact your child's school experience. _________________________

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