

# Kindergarten Student Information

\*Please have this completed prior to your School Visit and bring with you.\*

Name: \_\_\_\_\_

Birthdate: \_\_\_\_\_

Main Contact: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

Phone # of Main Contact: (cell) \_\_\_\_\_ (home) \_\_\_\_\_

Email address: \_\_\_\_\_

Preferred method of contact: phone/email/in-person

Name of person/s approved to pick child up from school:

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

Name/Grade/Age of siblings:

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

Medical Concerns, alerts or diagnosis?      Yes    No

\_\_\_\_\_

Allergies:    Yes    No

\_\_\_\_\_

Does your Child use the washroom independently?      Yes    No

\_\_\_\_\_

Have they attended Preschool or Daycare?

\_\_\_\_\_

Interests:

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Dislikes/Fears:

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What 3 words would you use to describe your child?

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Hand preference?      Left    Right    Both

Speech Concerns?      Yes    No

Vision Concerns?      Yes    No

Hearing Concerns?      Yes    No

Movement Concerns?      Yes    No

Is there anything else you would like us to know about your child?

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