Child Information Form:

We are grateful for the trust and interest you have shown in choosing our kindergarten for your child. Our aim is to unlock your child's potential and establish a strong foundation for their future happiness.
Leveraging our extensive experience, we have developed a questionnaire with carefully crafted questions. Each question holds significance and will aid us in gaining a deeper understanding of your child, enabling us to provide the best possible guidance and support as they progress with us. Please be assured that all information provided will be treated as confidential and utilized solely for internal purposes within the kindergarten. We sincerely appreciate your cooperation in completing this questionnaire.

Bystrá škôlka team

1. Basic Information About the Child:

Name and surname:	Citizenship:
Date birth:	Nationality:
Name a surname of the mother:	Name a surname of the father:
Tel. no.:	Tel. no.:

2. Physical Development and Medical History of the Child:

Has your child experienced any significant illnesses or medical conditions that necessitated extended hospitalization or separation from parents? **YES / NO**

Has the child experienced a more severe injury? **YES / NO** **If yes, please provide details including when and what happened:** _____

Does the child experience: **frequent colds, fevers, sore throat, respiratory ailments, nosebleeds, headaches, dizziness, abdominal pain, vomiting** (please circle all that apply)
Other: _____

- **Does the child have any congenital or acquired disorders: A, sight B, hearing C, speech D, doesn't have E,** musculoskeletal system, please specify:_____
  F internal organs, please specify: _____

- **Does the child experience any neurotic difficulties? wetting themselves / insomnia / stutter / does not have any, other:** _____
- **Is the child under special/professional care? YES / NO**

  *If yes, please specify the type of care (psychologist, special or therapeutic pedagogue, neurologist, physiotherapist, other):*_____
  If so, please provide a report from the relevant specialist when your child begins kindergarten.

- **Does the child have any medical restrictions?** (e.g. allergies to food, medications, plants, animals, mobility restrictions, etc.) **YES / NO**
  If YES, please specify: _____
  Allergies to food require confirmation from a doctor.
- **What medication does the child take?**_____

(specify a reason) _____

3. Social Development and Personality of the Child

- **How do you address the child at home?** _____
- **How many members are there in your family?** ___
- **Do you live in a shared household? YES / NO** **What are the ages of the siblings?** _____

- **Who does the child spend the most time with presently?** _____
- **Do you take your child to interact with peers** (e.g., to the playground, on visits, etc.):
  YES / OFTEN / OCCASIONALLY / NO
- **If necessary, do you leave your child in the care of another familiar adult for an extended period** (e.g., grandparents, neighbors, acquaintances)? **YES / OFTEN / OCCASIONALLY / NO**
- **If you answered no, has your child been without you as a parent for more than an hour, at least once** (e.g., stayed with grandparents)? **YES / NOT YET / NO, WE ARE AFRAID**
- **Does your child cry when separated from the person they are fixated on, requiring their constant attention** (e.g., if fixated on mum and staying with dad)? **YES, ALWAYS / OCCASIONALLY / NO**
- **How does your child react to the presence of unfamiliar adults in a new or unfamiliar environment (e.g., during a visit)?**
  A, immediately communicates with them
  B, needs time to get used to them
  C, stays in the parent's presence all the time - afraid
  D, other (please, specify)
  _____
- **Is/was your child attending any clubs/interest activities (including your presence), in which he/she has come into contact with a tutor/teacher?** **YES / NOT YET / ATTENDED**, (please, specify) _____
- **Is/was your child attending another preschool/nursery?**
  NOT YET / YES (FOR HOW LONG) _____
- **If you answered yes, has your child had a negative experience with adaptation in the past?**
  _____
- **What is your biggest concern about your child entering kindergarten?** (you can also tick more than one option)
  A, morning crying
  B, emotional discomfort (irritability, anxiety)
  C, frequent illnesses
  D, rejection of food
  E, rejection of rest time
  F self-care problems
  G, difficulty in integrating into the group, making new friends
  H, relationship between teachers and children
  I, early wake-up time
- **Other peculiarities or habits of the child that could significantly affect the adaptation process:**
  _____
- **Are you preparing your child for entry into daycare/preschool?** **YES / NO**
- **How would you describe the personality traits of your child? (**please circle all that apply):
  calm, approachable, friendly, solitary, alert, mostly cheerful, sad, tearful, fearful, impulsive, stubborn, shy, full of energy, other: _____
- **What challenges you in your child's behavior?** (e.g. excessive liveliness, conflict inducing behaviour, cooperation, acceptance and reaction to changes….): _____
- **What helps your child cope with strong emotions?** (joy, fear, anger, sadness):
  _____
- **Is there anything your child is afraid of?** (e.g. vacuum cleaner, insect, noise...) _____

- **Does your child have any bad habits? e.g., nail biting, biting lips, finger sucking, other:** _____
- **What are your child's interests?** (e.g. favorite toys, activities, sports, books): _____

_____

- **What is your child's interest in other children when playing in their presence (on the playground, in the sandbox, visiting, etc.)?**
  A, joins the other children, enjoys being around other children
  B, plays alone, shows no interest in other children's play
  C, watches other children, does not play
  D, spoils other children's play
  E, we do not know, the child doesn't come into contact with other children
  F, prefers to be in the presence of adults rather than children
  G, other (please describe your own experience)

- **How does your child typically respond to setbacks, such as not being able to complete a desired activity or build a sandcastle?**
  A, cries
  B, makes another attempt at the activity
  C, moves on to another activity
  D, unsure
  E, other (please describe your own experience)

- **Does your child assist you with tasks such as tidying up toys or putting away clothes? YES / NO / PARTIALLY**

4. Child's Communication Skills:

- **What language(s) do you use to communicate with your child?** (e.g., father in English, mother in Slovak):

_____

- **The child primarily communicates in which language:**
  A, Slovak
  B, another (specify):_____

- **How does your child communicate?**
  A, communicates verbally (age-appropriate), and is well understood
  B, communicates verbally, but not well understood
  C, communicates verbally with difficulty, using limited vocabulary and simple sentences,
  D, non-verbal communication predominates (gestures, signs, etc.)
  E, does not communicate
- **How does your child communicate his/her needs** (hunger, thirst..)**?** _____
- **How does your child signal that he/she needs to use the bathroom?** _____
- **Are there any specific syllables your child struggles to pronounce or pronounces incorrectly** (e.g., r, l, š, c, k...)**?** : _____
- **Does your child attend speech therapy? YES / NO**
  *If yes, for how long:*_____
  If yes, please provide a report from the speech therapist when your child starts kindergarten so we can better understand how to work with your child.
- **Does your child enjoy conversing or is he/she reserved and quiet? YES / NO**

5. Independence (Self-Care)

Choose one option for each item and indicate it with an "x"

MARK THE APPLICABLE	handles independently *(1)	can manage with help *(2)	cannot manage *(3)	I can't say
Removes/puts on shoes				
Puts on simple clothing (e.g., T-shirt, sweatpants...)				
Undresses from simple clothing (e.g., sweatpants, T-shirt...)				
Uses a handkerchief or tissues				
Cleans and dries hands				
Uses the toilet for urinating				
Uses the toilet for defecating				

(1) - (the child can independently perform the activity without adult assistance)
(2) - (the child can perform the activity partially and requires adult assistance)
(3) - (the activity is not within the child's current capabilities, and he/she has not yet mastered self-care habits, thus requiring adult assistance in full)

Additional Information:

- For urination, my child uses (choose): **DIAPER** **POTTY** **TOILET**
- For defecation, my child uses (circle): **DIAPER** **POTTY** **TOILET**
- Does your child require a diaper during the day? **YES / DURING SLEEPTIME, OTHERWISE NO/ NO**

Dining and Mealtime Habits:

Does your child eat with a spoon? **YES / NO** Does your child use cutlery (fork, knife)? **YES / NO**
Does your child drink from a cup? **YES / NO**
Is there any food that your child refuses to eat? **YES / NO**
If yes, please specify the reason (negative experience, allergic reaction...) _____
What is your child's overall attitude towards food: **POSITIVE / NEUTRAL / NEGATIVE**
Please circle or describe: _____

Sleep:

How does your child feel about sleep/rest? **POSITIVE / NEGATIVE**
Does your child fall asleep during afternoon rest? **YES / OCCASIONALLY / NO**
Does your child fall asleep with a favorite toy (if yes, which one)? **NO / YES** _____
Does your child wear a diaper when sleeping? **YES / NO**
Does your child wet the bed when sleeping? **YES, OFTEN / OCCASIONALLY / NO**

6. What Are Your Expectations From Bystrá Škôlka?

_____
_____

7. Additional Information for Teachers:

_____
_____

Thank you for completing the questionnaire. We are excited about the opportunity to nurture and support your child's growth and development.