

To be filled out by a primary parent or guardian:

Thank you for taking the time to complete this questionnaire. When completed, please mail or submit directly to Sonrise Christian School. It will be used in the best interest of your child to evaluate and help determine areas of strength and potential areas of growth. It will be held in confidence by administration and your child's teacher(s).

**YOUR NAME:** \_\_\_\_\_ **RELATIONSHIP TO STUDENT:** \_\_\_\_\_

**STUDENT'S NAME:** \_\_\_\_\_ **TODAY'S DATE:** \_\_\_\_\_

**STUDENT INFORMATION**

YES NO

Please explain all "NO" answers:

- |  |                          |                          |       |
|--|--------------------------|--------------------------|-------|
| Can your child speak a sentence using more than 5 words?       | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Does your child use their fork and spoon independently?        | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Does your child go to the bathroom independently?              | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Does your child exhibit aggressive, timid or fearful behavior? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Is your child happy and joyful most of the time?               | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Does your child express a wide range of emotions?              | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Does your child have trouble eating or sleeping?               | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

As best you can remember, please specify the age at which your child did the following:

**DEVELOPMENTAL MILESTONES**

AGE (years)

AGE (months)

Please explain any areas of concern:

- |                              |       |       |       |
|------------------------------|-------|-------|-------|
| Established eye contact      | _____ | _____ | _____ |
| Showed a fear of strangers   | _____ | _____ | _____ |
| Spoke his or her first words | _____ | _____ | _____ |
| Dressed self completely      | _____ | _____ | _____ |
| Became fully potty trained   | _____ | _____ | _____ |

Did your child have difficulties in separating from you when left with others? How did your child respond when you returned?

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

Did your child have any delays or difficulties in motor coordination? If so, please describe (include ages):

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

Did your child have any delays or difficulties in speech? If so, please describe (include ages):

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

# INCOMING PARENT QUESTIONNAIRE (CONTINUED)

---

Applicant Full Name \_\_\_\_\_

Have any of the following areas been of concern to you? (check all the apply)

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Lack of social skills       | <input type="checkbox"/> Shy                                   | <input type="checkbox"/> Difficulty expressing what he/she wants to say |
| <input type="checkbox"/> Impulsive                   | <input type="checkbox"/> Restless, trouble sitting still       | <input type="checkbox"/> Overly sensitive to sounds                     |
| <input type="checkbox"/> Difficulty paying attention | <input type="checkbox"/> Overly dependent                      | <input type="checkbox"/> Difficulty following directions                |
| <input type="checkbox"/> Upset with change           | <input type="checkbox"/> Difficulty understanding what is said | <input type="checkbox"/> Unusual fears or phobias                       |

Are any of those areas of current concern to you? If so, please describe:

---

---

Describe your child's strengths with regard to academic abilities, social skills, behavior, etc.

---

---

How would you describe your child's personality?

---

---

Have any of the following events occurred in child's life?

<b>EVENTS</b>	YES	NO	Please describe your child's response or behavior following this event.
Moved to a new home	<input type="checkbox"/>	<input type="checkbox"/>	_____
Extended separation from parent	<input type="checkbox"/>	<input type="checkbox"/>	_____
Serious illness or injury	<input type="checkbox"/>	<input type="checkbox"/>	_____
Death in the family	<input type="checkbox"/>	<input type="checkbox"/>	_____
Divorce or marital separation	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other (please specify)	<input type="checkbox"/>	<input type="checkbox"/>	_____

Please list anything else you think we should know:

---

---

---

---

**Please mail or fax this completed form to: Sunrise Christian School**

1220 E. Ruddock Street, Covina, CA 91724 • 626.331.0559 • fax: 626.339.8029 • sunrisechristian.org