Dear Little Clipper Families,

We are excited that you and your child are participating in our Little Clipper Prekindergarten program this school year. Your child's teacher and administrator will support your child with joyful and interactive lessons to give them the foundation needed for kindergarten and a lifetime of learning. These efforts include monitoring and supporting your child's progress on a wide range of social and academic skills as well as language development throughout the school year.

Our program screens children for possible developmental and instructional needs, per New York State Universal Prekindergarten regulations. The Early Screening Inventory (ESI) will be administered in May, or if your child is new to the program, during the late summer or within the first few weeks of school. This screening will assist your child's teacher in learning more about the various aspects of your child's development and instructional needs. This screening does not determine readiness for Prekindergarten. It is not a test of IQ or related to their knowledge of academics (letters or numbers, etc.). Results of the screening will be shared and any developmental or instructional needs will be addressed.

The Early Screening Inventory (ESI) is a brief developmental screening instrument designed to be individually administered to children from 3.5 to 5.11 years of age. The purpose of the screening is to identify children who may need extra support in order to be ready for school activities. The instrument addresses developmental, sensory, and behavioral concerns in the following areas:
Visual Motor/Adaptive: block building, drawing, copying forms
Language and Cognition: verbal expression, speech and articulation, and memory
Gross Motor Skills: jumping, hopping, and other physical coordination tasks

We are also asking you to complete the Parent Questionnaire. Please be as honest as possible when answering questions. The information from the Parent Questionnaire is used to interpret results of the screening. Please return the completed Parent Questionnaire with your registration packet. Thank you for your ongoing support!

Sincerely,

The Little Clippers Prekindergarten Team

Early Screening Inventory·Revised™ Meisels et al.

Parent Questionnaire

Date _____

CHILD INFORMATION

CHILD'S NAME _____ ☐ Male ☐ Female

HOME ADDRESS Street _____ Apt _____

City _____ State _____ Zip _____

Phone (_____) _____ Date of Birth _____

Who is completing this Parent Questionnaire? Name _____

Relationship to child _____

FAMILY

With whom has the child lived for most of the past year? _____

_____

Other children in the family – How many older? _____ How many younger? _____

Other people living in the household _____

What language(s) are spoken at home? ☐ English ☐ Other (specify) _____

PRESCHOOL/CHILD CARE HISTORY

Has your child attended preschool/child care before? ☐ Yes ☐ No

If yes, for how long? ☐ 6 months ☐ 1 year ☐ 2 years ☐ more than 2 years

Name of child's present or most recent school _____

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MEDICAL HISTORY

Birth

Were there any significant problems during pregnancy? ☐ Yes ☐ No

If yes, please explain:

Was your child more than 3 weeks premature? ☐ Yes ☐ No

If yes, how many weeks premature? _____

Baby's birth weight _____

Did the baby stay in the hospital longer than the mother? ☐ Yes ☐ No

If yes, please explain:

At the time of birth, did the baby — have seizures ☐ Yes ☐ No

turn blue? ☐ Yes ☐ No

Child's Health Since Birth

EYES

Has your child ever had trouble seeing? ☐ Yes ☐ No

Does your child hold books and objects close to his or her face? ☐ Yes ☐ No

Have your child's eyes ever looked crossed? ☐ Yes ☐ No

Have you ever suspected that your child has vision problems? ☐ Yes ☐ No

If yes, please explain:

EARS

Has your child had frequent ear infections? ☐ Yes ☐ No

Has your child ever had trouble hearing? ☐ Yes ☐ No

Have you ever suspected that your child has hearing problems? ☐ Yes ☐ No

If yes, please explain:

COORDINATION

Has your child ever had trouble walking, climbing, reaching, holding on to things? ☐ Yes ☐ No

If yes, please explain:

MEDICAL HISTORY (continued)

Child's Health Since Birth continued

Has your child ever had any significant injuries or hospitalizations? ☐ Yes ☐ No

If yes, please explain:

Does your child have allergies? ☐ Yes ☐ No

If yes, please explain:

Is your child presently on any medications? ☐ Yes ☐ No

If yes, please explain:

Please describe any other health concerns: ☐ Yes ☐ No

SOCIAL, EMOTIONAL, AND SELF-HELP SKILLS

Can your child —

- feed him or herself using a spoon and/or a fork? ☐ Yes ☐ No
- wash and dry his or her own hands? ☐ Yes ☐ No
- help with dressing or dress with little assistance? ☐ Yes ☐ No
- stay with a babysitter? ☐ Yes ☐ No
- speak so that he or she can be understood by others? ☐ Yes ☐ No
- express his or her thoughts and needs easily? ☐ Yes ☐ No

Do you have any concerns about your child's appetite or willingness to try different foods? ☐ Yes ☐ No

If yes, please explain:

CHILD'S DEVELOPMENT (continued)

Do you have any concerns about your child's sleeping patterns (going to bed with difficulty or waking often during the night)? ☐ Yes ☐ No

If yes, please explain:

Is your child —	highly active?	☐ Yes ☐ No
	very quiet?	☐ Yes ☐ No
Is your child —	toilet trained during the day?	☐ Yes ☐ No
	in need of help with toileting?	☐ Yes ☐ No
Does your child —	play with blocks, boxes, cups, or other construction toys without help?	☐ Yes ☐ No
	use crayons and/or markers to scribble or draw?	☐ Yes ☐ No
	listen to stories being read?	☐ Yes ☐ No
	turn pages of a book and look at pictures?	☐ Yes ☐ No
	recall stories or events?	☐ Yes ☐ No
	enjoy playing alone or with imaginary friends?	☐ Yes ☐ No
	talk with your friends/relatives who come to visit?	☐ Yes ☐ No
	follow simple, age-appropriate directions?	☐ Yes ☐ No

What are your child's favorite activities?

Does your child have opportunities to play with other children? ☐ Yes ☐ No

How many hours a day does your child spend watching TV? _____

Does he or she sit very close to the TV? ☐ Yes ☐ No

Does he or she turn up the volume very high? ☐ Yes ☐ No

Are there other things you would like to tell us about your child?