



We Inspire. We Educate. We Graduate.
All Students, All of the Time

NEW STUDENT REGISTRATION

Welcome to the Kingston City School District

New students are registered by appointment at the Administrative Building located at 21 Wynkoop Place, Kingston, New York, 12401. The Registrar's office is open from 9:00 a.m. to 3:00 p.m. during the school year and from 9:00 a.m. to 2:00 p.m. throughout the summer. Parents should obtain and complete a registration packet prior to scheduling an appointment. Packets are available at the Registrar's office, at each of our school buildings and on the school website **kingstoncityschools.org**. To schedule an appointment, please call 845-943-3011.

PLEASE NOTE

1. The parent/legal guardian must be present at the time of registration and first visit to school.
2. Once all paperwork is complete and the Registration process is finalized, the Registrar will forward the information to the attending school(s). The school(s) will contact you directly your child's start date.

Required Forms to Complete for Registration:

1. Student Registration Form
2. Request for Records Form – not applicable for kindergarten
3. Health Inventory Form
4. Immunization Form
5. Home Language Questionnaire Form

Questions or to schedule an appointment:
Please call (845) 943-3011.

INFORMATION ABOUT SPECIAL EDUCATION UPON ENTRY TO SCHOOL
Chapter 434 of the Laws of 2014

Statute: Section 4402

Effective Date: July1, 2015

Summary:

This amendment requires school districts to notify every parent or person in parental relation of their rights regarding the referral and evaluation of their child for the purposes of special education services or programs. This notification shall be provided to the parents of all students in the district (with and without disabilities) upon their child's entry into public school. Districts may provide this information to parents by directing them to *A Parent's Guide to Special Education* on the New York State Education Department's (NYSED's) web site, provided that the district includes the name and contact information of the district's Committee on Special Education chairperson or other appropriate special education administrator. NYSED's *A Parent's Guide to Special Education* is available in both English and Spanish.

Statute: Chapter 434 of the Laws of 2014

Section 1. Section 4402 of the education law is amended by adding a new subdivision 8 to read as follows:

8. Upon their child's enrollment or attendance in a public school, such school shall notify every parent or person in parental relation of their rights regarding referral and evaluation of their child for the purposes of special education services or programs pursuant to applicable federal and state laws. Such notification may be provided by directing parents or persons in parental relation to obtain information located on the department's website relating to a parent's guide to special education in New York state for children ages three through twenty-one provided the notification shall also contain the name and contact information for the chairperson of the school district's committee on special education or other individual who is charged with processing referrals to the committee in the district.

Beth Lewis-Jackson - 845-943-3061
Director of Special Education Services
Kingston City School District
blewis@kingstoncityschools.org

Student Name _____, _____ School / Grade _____
Last First

Parent/Guardian Name _____ Phone # _____



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Dr. Paul J. Padalino
Superintendent of Schools

CHECKLIST FOR KINDERGARTEN REGISTRATION

The following documents are required for enrolling into the Kingston City School District

- ☐ **Birth Certificate, Passport, or Baptismal Certificate**
- ☐ **Immunization Record**
Prepared by a physician or authorized person who administers the immunizing agent and shall specify the vaccines given and the dates of administration, proof of past immunizations or proof of pending appointment with physician/medical practice.
- ☐ **Custody/Guardian papers:** Necessary if the child does not live with both biological parents
- ☐ **Parent or Guardian photo identification:** Driver's License, passport, state id.
- ☐ **District Residency**
One of the following residency proofs must be provided:
 - A. Owns home, or**
 - 1. Most recent utility bill/tax or mortgage statement – must have name and property/residence address
 - B. Rents home, or**
 - 1. Lease agreement, must have name property/residence address
 - 2. Parent's name must appear on lease
 - 3. Most recent utility bill – one only (electric, phone, water bill) must have name and property/residence address
 - C. Affidavit of Property Owner/Landlord Form – Must be Notarized**
 - 1. To be completed by the landlord/property owner, in instances where there is no lease
 - 2. If you are living with a relative, that person must complete the form and also provide you with a bill (electric, phone, water) showing their name and property/residence address

** The following will not be accepted as proof of residency: Driver's License, Checkbook, Rent Receipt, Car Insurance Cards, and Bank Statements.

****CLASSIFIED – YES or NO**

KINGSTON CITY SCHOOL DISTRICT PUPIL REGISTRATION FORM

DATE _____ GRADE _____

Student Name _____ Gender _____ Hispanic? ☐ Yes ☐ No
(Last) (First) (Middle)

Race (choose all that apply): ☐ Asian ☐ Black ☐ Native American/Native Alaskan ☐ Pacific Islander ☐ White

Date of Birth _____ Place of Birth (city, state) _____ Country (if not US) _____

Pre K Experience ☐ Yes ☐ NO

Has pupil ever attended school in this district: Yes _____ No _____

If yes, which school _____ Grade(s) _____

Name of last school attended _____ Grades attended in previous school _____

Address of school last attended _____

Phone/Fax (circle one) (if known) _____ If high school: date entered 9th grade _____

For Immigrant Students and ESL (English as a second language) students ONLY

ESL? ☐ Yes ☐ No

Date of US Entry: _____ Date First Entered School in US _____

These questions address the McKinney-Vento Act 42 U.S.C. 11435. This information helps determine eligibility for services:

1. Is your current address a temporary living arrangement? ☐ Yes ☐ No If "No" stop here. If "Yes" please continue:

2. Is your temporary living arrangement due to loss of housing or economic hardship? ☐ Yes ☐ No

Where is the student presently living?

☐ In a motel ☐ In a shelter ☐ With more than one family in a house or apartment ☐ Moving from place to place

☐ In a place not designed for ordinary sleeping accommodations such as a car, park, or campsite.

PARENTS/GUARDIANS WITH WHOM CHILD(REN) RESIDE(S)

Home Phone _____ Unlisted? ☐ Yes ☐ No Contact Priority _____

Address _____ City _____ State _____ Zip _____

Mailing Address, if different _____

Dominant Home Language _____ ESL ☐ YES ☐ NO

Resident Type: ☐ Lease ☐ Own ☐ Rent ☐ Trailer Park/Condo Unit ☐ Unknown

Proof of Residency: ☐ Mortgage Statement ☐ Property Tax Bill ☐ Real Estate Statement ☐ Utility Bill

☐ Lease ☐ Landlord Verification Form ☐ Other _____

INFORMATION TO BE COMPLETED FOR PARENTS/GUARDIANS WHO LIVE IN THE SAME HOUSEHOLD AS THE CHILD(REN):

Parent/Guardian Name _____
(Last) (First) (Middle)

Relationship _____ Legal custody? ☐ YES ☐ NO

Cell Phone _____ Contact Priority _____

Work Phone _____ Contact Priority _____

Email Address _____

Employer's Name _____

Employer's Address _____
(City) (State/Zip)

Currently Serving Active Military Duty ☐ YES ☐ NO If yes, date enlisted: _____ Date Exited: _____

Parent/Guardian Name _____
(Last) (First) (Middle)

Relationship _____ Legal custody? ☐ YES ☐ NO

Cell Phone _____ Contact Priority _____

Work Phone _____ Contact Priority _____

Email Address _____

Employer's Name _____

Employer's Address _____
(City) (State/Zip)

Currently Serving Active Military Duty ☐ YES ☐ NO If yes, date enlisted: _____ Date Exited: _____

INFORMATION TO BE COMPLETED FOR A PARENT/GUARDIAN WHO DOES NOT LIVE IN THE SAME HOUSEHOLD AS THE CHILD(REN):

Name _____
(Last) (First) (Middle)

Relationship _____

Address _____

Address _____ Correspondence ☐ Yes ☐ No
(City) (State/Zip)

Home Phone _____ Contact Priority _____

Cell Phone _____ Contact Priority _____

Work Phone _____ Contact Priority _____

Email Address _____

Currently Serving Active Military Duty ☐ YES ☐ NO If yes, date enlisted: _____ Date Exited: _____



STATE EDUCATION DEPARTMENT / THE UNIVERSITY OF THE STATE OF NEW YORK / ALBANY, NY 12234
Office of P-12

Lisette Colón-Collins, Assistant Commissioner
Office of Bilingual Education and World Languages

55 Hanson Place, Room 594
Brooklyn, New York 11217
Tel: (718) 722-2445 / Fax: (718) 722-2459

89 Washington Avenue, Room 528EB
Albany, New York 12234
(518) 474-8775 / Fax: (518) 474-7948

Home Language Questionnaire (HLQ)

Dear Parent or Guardian:
In order to provide your child with the best possible education, we need to determine how well he or she understands, speaks, reads and writes in English, as well as prior school and personal history. Please complete the sections below entitled Language Background and Educational History. Your assistance in answering these questions is greatly appreciated. Thank you.

Please write clearly when completing this section.

STUDENT NAME:

First Middle Last

DATE OF BIRTH:

Month Day Year

GENDER:

☐ Male
☐ Female

PARENT/PERSON IN PARENTAL RELATION INFO:

Last Name First Name Relation to Student

HOME LANGUAGE CODE

Language Background (Please check all that apply.)

1. What language(s) is(are) spoken in the student's home or residence?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____ specify
2. What was the first language your child learned?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____ specify
3. What is the Home Language of each parent/guardian?	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	_____ specify
	<input type="checkbox"/> Guardian(s)		_____ specify
4. What language(s) does your child understand?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____ specify
5. What language(s) does your child speak?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____ specify <input type="checkbox"/> Does not speak
6. What language(s) does your child read?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____ specify <input type="checkbox"/> Does not read
7. What language(s) does your child write?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____ specify <input type="checkbox"/> Does not write

THIS SECTION TO BE COMPLETED BY DISTRICT IN WHICH STUDENT IS REGISTERED:

SCHOOL DISTRICT INFORMATION:

STUDENT ID NUMBER IN NYS STUDENT INFORMATION SYSTEM:

District Name (Number) & School

Address

Home Language Questionnaire (HLQ)—Page Two

Educational History

8. Indicate the total number of years that your child has been enrolled in school _____

9. Do you think your child may have any difficulties or conditions that affect his or her ability to understand, speak, read or write in English or any other language? If yes, please describe them.

Yes* No Not sure

☐ ☐ ☐ *If yes, please explain: _____

How severe do you think these difficulties are? ☐ Minor ☐ Somewhat severe ☐ Very severe

10a. Has your child ever been referred for a special education evaluation in the past? ☐ No ☐ Yes* *Please complete 10b below

10b. *If referred for an evaluation, has your child ever received any special education services in the past?

☐ No ☐ Yes – Type of services received: _____

Age at which services received (Please check all that apply):

☐ Birth to 3 years (Early Intervention) ☐ 3 to 5 years (Special Education) ☐ 6 years or older (Special Education)

10c. Does your child have an Individualized Education Program (IEP)? ☐ No ☐ Yes

11. Is there anything else you think is important for the school to know about your child? (e.g., special talents, health concerns, etc.)

12. In what language(s) would you like to receive information from the school? _____

Signature of Parent or of Person in Parental Relation

Month: _____ Day: _____ Year: _____
Date

Relationship to student: ☐ Mother ☐ Father ☐ Other: _____

OFFICIAL ENTRY ONLY - NAME/POSITION OF PERSONNEL ADMINISTERING HLQ

NAME: _____ POSITION: _____

IF AN INTERPRETER IS PROVIDED, LIST NAME, POSITION AND CREDENTIALS:

NAME/POSITION OF QUALIFIED PERSONNEL REVIEWING HLQ AND CONDUCTING INDIVIDUAL INTERVIEW

NAME: _____ POSITION: _____

ORAL INTERVIEW NECESSARY: ☐ No ☐ Yes

**DATE OF INDIVIDUAL
INTERVIEW:

MO. DAY YR.

OUTCOME OF
INDIVIDUAL
INTERVIEW:

☐ ADMINISTER NYSITELL
☐ ENGLISH PROFICIENT
☐ REFER TO LANGUAGE PROFICIENCY TEAM

NAME/POSITION OF QUALIFIED PERSONNEL ADMINISTERING NYSITELL

NAME: _____ POSITION: _____

DATE OF NYSITELL
ADMINISTRATION:

MO. DAY YR.

PROFICIENCY LEVEL
ACHIEVED ON
NYSITELL:

☐ ENTERING ☐ EMERGING ☐ TRANSITIONING ☐ EXPANDING ☐ COMMANDING

FOR STUDENTS WITH DISABILITIES, LIST ACCOMMODATIONS, IF ANY, ADMINISTERED IN ACCORDANCE WITH IEP PURSUANT TO CSE RECOMMENDATION:

Kingston City School District

HEALTH HISTORY for REGISTRATION & ATHLETES

Please complete in blue or black ink.

Name:			DOB:	Age:	Gender:
School:			Grade:		<input type="checkbox"/> M <input type="checkbox"/> F
Parent/Guardian: (person completing this form)			Home Phone:		Date:
			Cell Phone:		
Has your child ever:	YES	NO	If Yes, please explain and include date:		
Had an ongoing medical condition/medical specialist	<input type="checkbox"/>	<input type="checkbox"/>			
Had allergies:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> food <input type="checkbox"/> environmental <input type="checkbox"/> insect <input type="checkbox"/> medication <input type="checkbox"/> other		
Been hospitalization/Had an operation	<input type="checkbox"/>	<input type="checkbox"/>			
Had an injury requiring an Emergency Room visit	<input type="checkbox"/>	<input type="checkbox"/>			
Missed 5 days of school in a row due to illness/injury	<input type="checkbox"/>	<input type="checkbox"/>			
Had a bone/muscle injury	<input type="checkbox"/>	<input type="checkbox"/>			
Passed out, had a concussion or serious head injury	<input type="checkbox"/>	<input type="checkbox"/>			
Had a convulsion/seizure	<input type="checkbox"/>	<input type="checkbox"/>			
Had a vision problem or condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> glasses <input type="checkbox"/> contacts		
Had a hearing problem or condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> hearing aid <input type="checkbox"/> cochlear implant		
Worn dental bridge, braces or mouthpiece	<input type="checkbox"/>	<input type="checkbox"/>			
Cardiac History:	YES	NO	If Yes, please specify:		
Has anyone in your immediate family had any serious cardiac history such as: heart attack or sudden cardiac death under the age of 50, irregular heart beat, pacemaker, cardiomyopathy, structural defects, genetic heart defects	<input type="checkbox"/>	<input type="checkbox"/>			
Has your student had any irregular heartbeats, symptoms during or after exercise, fainting	<input type="checkbox"/>	<input type="checkbox"/>			

CHECK ALL THAT APPLY TO YOUR CHILD:

- | | | |
|--|---|---|
| <input type="checkbox"/> ADHD
<input type="checkbox"/> Asthma/trouble breathing
<input type="checkbox"/> Autism/Asperger
<input type="checkbox"/> Dental Injuries
<input type="checkbox"/> Diabetes
<input type="checkbox"/> Ear Infections | <input type="checkbox"/> GI Conditions (ulcer, reflux, IBS)
<input type="checkbox"/> Headaches/migraines
<input type="checkbox"/> Heart Conditions
<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Mental Health Condition
(depression, eating disorder, anxiety,
OCD, ODD, etc.) | <input type="checkbox"/> Scoliosis
<input type="checkbox"/> Single Organ (<input type="checkbox"/> kidney, <input type="checkbox"/> testicle)
<input type="checkbox"/> Skin Condition
<input type="checkbox"/> Speech Condition
<input type="checkbox"/> Urinary Condition |
|--|---|---|

CURRENT MEDICATIONS	YES	NO	Please list name, dose, time(s)
Given at school	<input type="checkbox"/>	<input type="checkbox"/>	
Taken at home	<input type="checkbox"/>	<input type="checkbox"/>	
ASSISTIVE EQUIPMENT	YES	NO	Please check all that apply
During or outside of school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> crutches <input type="checkbox"/> walker <input type="checkbox"/> wheelchair <input type="checkbox"/> other:
TREATMENTS	YES	NO	
During or outside of school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> insulin/blood glucose monitoring <input type="checkbox"/> inhaler/nebulizer/peak flow monitoring <input type="checkbox"/> special diet

Is there any condition that would prevent your child from participating in physical education or sports?

☐ No ☐ Yes: _____

Please list any additional concerns: (use back of sheet if necessary) _____

Parent/Guardian Signature: _____ Date: _____



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Superintendent of Schools

AFFIDAVIT OF PROPERTY OWNER/LANDLORD
IN SUPPORT OF RESIDENCY IN THE KINGSTON CITY SCHOOL DISTRICT

I, _____ a property owner or manager/agent of the dwelling located at
(Name of Property Owner/Landlord or Property Manager)

(Street Address/Apt #)

(City, State, Zip)

Hereby certify that I am renting space in this dwelling on a _____ basis beginning on _____
(Weekly/monthly/yearly) (Date)

The following persons are identified as tenants having the right to be occupants in the dwelling:

- Parent/Guardian: _____
- Parent/Guardian: _____

Student Name: _____ Grade: _____

Student Name: _____ Grade: _____

Student Name: _____ Grade: _____

Student Name: _____ Grade: _____

Student Name: _____ Grade: _____

The payment of Electric Utility Bill is included in rent: Yes: _____ No: _____

I certify that the information provided on this form is true and correct and that the statements made herein are being made under the penalties of perjury, knowing that the Kingston City School District will rely upon them in determining whether the above-named child(ren) reside in the school district.

(Signature of Property Owner/Landlord or Property Manager)

Sworn to before me on this
_____ Day of _____, 20____

(Print Name)

(Notary Public)
State of:
County of:

60 Month Questionnaire 54 months 0 days through 72 months 0 days



Questions about behaviors children may have are listed on the following pages. Please read each question carefully and check the box ☒ that best describes your child's behavior. Also, check the circle ☒ in the last column if the behavior is a concern.

Important Points to Remember:

- ☐ Answer questions based on what you know about your child's behavior.
- ☐ Answer questions based on your child's *usual* behavior, not behavior when your child is sick, very tired, or hungry.
- ☐ Caregivers who know the child well and spend more than 15–20 hours per week with the child should complete ASQ:SE-2.

*If you have any questions or concerns about your child or about this questionnaire, contact the KCSD Registrar: 845-943-3011; registration@kingstoncityschools.org

	OFTEN OR ALWAYS	SOME-TIMES	RARELY OR NEVER	CHECK IF THIS IS A CONCERN	
1. Does your child look at you when you talk to them?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
2. Does your child cling to you more than you expect?	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/> v	_____
3. Does your child like to be hugged or cuddled?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
4. Does your child talk or play with adults they know well?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
5. When upset, can your child calm down within 15 minutes?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
6. Does your child seem too friendly with strangers?	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/> v	_____
7. Does your child settle himself/herself down after exciting activities?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
8. Does your child seem happy?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____



TOTAL POINTS ON PAGE _____

60 Month Questionnaire



Check the box ☒ that best describes your child's behavior.
Also, check the circle ☒ in the last column if the behavior is a concern.

	OFTEN OR ALWAYS	SOME-TIMES	RARELY OR NEVER	CHECK IF THIS IS A CONCERN	
9. Does your child cry, scream, or have tantrums for long periods of time?	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/> v	_____
10. Is your child interested in things around them, such as people, toys, and foods?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
11. Does your child go to the bathroom by himself/herself? (Reminders and help with wiping are okay.)	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
12. Does your child have eating problems? For example, do they stuff food, vomit, eat things that are not food, or _____? (Please describe.)	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/> v	_____

13. Does your child stay with activities they enjoy for at least 15 minutes (other than watching shows or videos, or playing with electronics)?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
14. Do you and your child enjoy mealtimes together?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
15. Does your child do what you ask them to do? For example, do they wash their hands or wait to take a turn when asked?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
16. Does your child seem more active than other children their age?	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/> v	_____
17. Does your child sleep at least 8 hours in a 24-hour period?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
18. Does your child use words to tell you what they want or need?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____

TOTAL POINTS ON PAGE _____

60 Month Questionnaire



Check the box ☒ that best describes your child's behavior.
Check the circle ☒ in the last column if the behavior is a concern.

	OFTEN OR ALWAYS	SOME-TIMES	RARELY OR NEVER	CHECK IF THIS IS A CONCERN	
19. Does your child use words to describe his/her feelings and the feelings of others? For example, do they say, "I'm happy," "I don't like that," or "She's sad?"	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
20. Does your child move from one activity to the next with little difficulty (for example, from playtime to mealtime)?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
21. Does your child explore new places, such as a park or a friend's home?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
22. Does your child do things over and over and get upset when you try to stop them? For example, do they rock, flap hands, spin, or _____? (Please describe.) _____ _____	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/> v	_____
23. Does your child hurt himself/herself on purpose?	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/> v	_____
24. Does your child follow rules at home or at child care?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
25. Does your child destroy or damage things on purpose?	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/> v	_____
26. Does your child stay away from dangerous things, such as fire and moving cars?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
27. Does your child show concern for other people's feelings? For example, do they look sad when someone is hurt?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
28. Do other children like to play with your child?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____



TOTAL POINTS ON PAGE _____

60 Month Questionnaire



Check the box ☒ that best describes your child's behavior. Also, check the circle ☒ in the column if the behavior is a concern.

	OFTEN OR ALWAYS	SOME-TIMES	RARELY OR NEVER	CHECK IF THIS IS A CONCERN	
29. Does <i>your child</i> like to play with other children?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
30. Does your child try to hurt other children, adults, or animals (for example, by kicking or biting)?	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/> v	_____
31. Does your child take turns and share when playing with other children?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
32. Does your child wake three or more times during the night?	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/> v	_____
33. Is your child too worried or fearful? If "sometimes" or "often or always," please describe: _____ _____ _____	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/> v	_____
34. Does your child have simple back-and-forth conversations with you? For example: Parent: "It's raining!" Child: "And cold outside." Parent: "Let's get your coat." Child: "I got it!"	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
35. Has anyone shared concerns about your child's behaviors? If "sometimes" or "often or always," please explain: _____ _____ _____	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/> v	_____

TOTAL POINTS ON PAGE _____

OVERALL Use the space below for additional comments.

36. Do you have concerns about your child's eating, sleeping, or toileting habits?

If yes, please explain:

☐ YES

☐ NO

37. Does anything about your child worry you? If yes, please explain:

☐ YES

☐ NO

38. What do you enjoy about your child?
