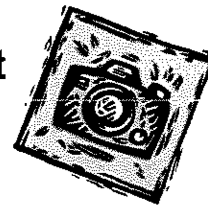
Transition to Kindergarten – Child Snapshot



Dear New Kindergarten Parent:
Congratulations on your child entering kindergarten! This is a very exciting time for both you and your child. In order to assist with your child's transition to kindergarten, please complete this information about your child who will be entering kindergarten and return it to your child's early childhood program by ______________. This information will be passed on to your child's new kindergarten teacher along with additional information completed by your child's current early childhood program.

What School District will your child enroll in?	What school do you expect your child to attend?

About Your Child

1. What is your child's name? ______________________________ First Middle Last Name	3. What is your child's date of birth? _____ / _____ / _____ Month Day Year
2. What name do you call your child by? ______________________________ Child's nick name	4. Will your child ride the bus to school? ☐ Yes ☐ No ☐ Not sure

5. What would you like your child's teacher to know about your child? (For example, personality, behavior, living arrangements, special needs, etc.)

About Your Family

6. Is your family new to this area? ☐ Yes ☐ No	7. What is the best language to communicate with you: ☐ English ☐ Spanish ☐ Other: ______________
8. Who are the children living in the home? Name Age Relationship ______________________________ ______________________________ ______________________________ ______________________________	9. Who are the adults living in the home? Names adults Relationship to Child ______________________________ ______________________________ ______________________________ ______________________________

10. Please describe any recent changes in your family that might affect your child.

Your Child's Health

11. Does your child ...	Yes	No	Not sure	Describe
a. Have any food allergies?	☐	☐	☐	
b. Have any other allergies (such as bee stings)?	☐	☐	☐	
c. Have any health problems (such as asthma)?	☐	☐	☐	
d. Wear glasses?	☐	☐	☐	
e. Take any medications?	☐	☐	☐	
f. Take a regular daytime nap?	☐	☐	☐	

Your Child's Early Childhood Education Experience

12. Has your child attended any of these programs? (Please mark all that apply)	Check if yes	How many months/years?	Was it full-time or part-time? (Full-time = 15 more hours per week and Part-time = less than 15 hours per week)
a. Preschool	☐	____ months or ____ years	☐ Full-time ☐ Part-time
b. Head start	☐	____ months or ____ years	☐ Full-time ☐ Part-time
c. Child care center	☐	____ months or ____ years	☐ Full-time ☐ Part-time
d. Family child care home	☐	____ months or ____ years	☐ Full-time ☐ Part-time
e. Summer Bridge Program	☐	____ months or ____ years	☐ Full-time ☐ Part-time
f. Other: ______________________	☐	____ months or ____ years	☐ Full-time ☐ Part-time

13. What is your child's current teacher's name and telephone number:

____

Name Phone Number Name of program

Your Permission to Share This Information

I give permission to provide this information to my child's kindergarten teacher.

Signature : ____

Print:

____

Name Relationship to Child Phone Number Date

Thank you!