KINDERGARTEN PARENT SURVEY
2003

Please fill in the circles like this ● or ⊗ NOT ✗ Please use blue or black pen.
If you make a mistake please cross it out ✗ and fill in the correct answer ●
Make sure your mark is within the circle

SECTION A: CHILD HEALTH & DEVELOPMENT

In this section, we would like to ask about your child's health. Your responses will help us determine the health status of Halton's children. When you are asked about "your child", please answer the question based on your child who is currently enrolled in senior kindergarten.

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1. What is your child's gender? ○ **Male** ○ **Female**

2. What is your child's birthdate? **mm** ☐☐ **dd** ☐☐ **yy** ☐☐

3. In general, would you say your child's health is: ○ **Excellent** ○ **Very Good** ○ **Good** ○ **Fair** ○ **Poor**

4. What is your child's:

Current Weight	**Birth Weight**	**Current Height**
☐☐ **lbs.** ☐☐ **oz.**	☐☐ **lbs.** ☐☐ **oz.**	☐☐ **ft.** ☐☐ **in.**
☐☐.☐ **kg.**	☐☐.☐ **kg.**	☐☐.☐☐ **m.**

(Kilograms to pounds: x 2.2046
Meters to feet: x 3.2808)

5. Does your child have any long-term health-problems? (health problems that have lasted or are expected to last 6 months or more and have been **diagnosed by a professional**, e.g., physician, psychologist, speech therapist, behavioural specialist). ○ **Yes** ○ **No**

(MARK ALL THAT APPLY)

Asthma	○	Developmental delay	○
Bronchitis	○	Speech impairment	○
Heart condition of any kind	○	Serious behaviour problem(s)	○
Epilepsy	○	Hearing impairment	○
Cerebral Palsy	○	Visual impairment	○
Kidney Condition or Disease	○	Physical impairment	○
Allergies	○	Autism spectrum disorder	○
Specific learning problem	○	Other condition (specify) ________________	○

6. Did your child attend a junior kindergarten (JK) program before starting senior kindergarten?

○ **YES, At School** ○ **Yes, At a Preschool or Child Care Centre** ○ **No, Did not attend a JK program**

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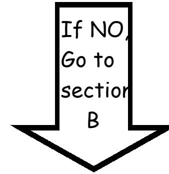
7. Before starting kindergarten, did you have any concerns about your child's:

	A lot of Concern	Some Concerns	No Concerns
a. Ability to play with other children	○	○	○
b. Learning	○	○	○
c. Behaviour	○	○	○
d. Physical abilities	○	○	○

8. Does your child have any special needs that would require services beyond those most children need?



Yes	No
○	○

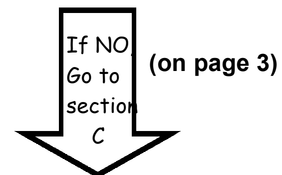
9. Indicate your level of agreement with the following statements:

	Strongly Disagree	Disagree	Agree	Strongly Agree	Don't Know
a. Your decision about the age at which to enroll your child in school was influenced by the availability of special services for your child	○	○	○	○	○
b. My expectations regarding school services and support have been met	○	○	○	○	○
c. I am satisfied with the availability of services offered by the school for my child	○	○	○	○	○
d. The change of services from pre-school to kindergarten was completed to my satisfaction	○	○	○	○	○

SECTION B: CHILD INJURY

The following questions refer to injuries, such as broken bones, bad cut or burn, head injury, poisoning, or a sprained ankle, which occurred in the past 12 months, and were ***serious enough to require medical attention, by a doctor, nurse or dentist***

1. In the past 12 months was your child injured? Yes ○ No ○



(on page 3)

For the next set of questions, think about the **most serious incident** where your child suffered an injury in the last 12 months and answer the questions based on the injury (ies).

2. What type of injury did he/she have?

Broken or Fractured Bones	○	Internal Injury	○
Burn or Scale	○	Dental Injury	○
Dislocation	○	Multiple injuries	○
Sprain or Strain	○	Other (specify) ______________	○
Cut, Scrape or Bruise	○		
Concussion	○		
Poisoning by substance or liquid	○		

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3. What part of his/her body was injured?

- Eyes ○
- Face or Scalp (excluding eyes) ○
- Head or Neck (excluding eyes & face or scalp) ○
- Arms or hands ○
- Trunk (excluding back or spine) (including chest, internal organs, etc.) ○
- Back or spine ○
- Legs or feet ○
- Shoulder ○
- Hip ○
- Multiple Sites ○

4. What type of incident was it? For example, was the injury the results of a fall, motor vehicle collision, a physical assault, etc.?

- Motor Vehicle Collision -passenger ○
- Motor Vehicle Collision -pedestrian ○
- Motor Vehicle Collision -riding bicycle ○
- Other Bicycle Accident ○
- Fall (excluding bicycle or sports) ○
- Sports (excluding bicycle) ○
- Physical Assault ○
- Scalded by Hot Liquids or Food ○
- Accidental Poisoning ○
- Self-Inflicted Poisoning ○
- Other Intentionally Self-Inflicted Injuries ○
- Natural/Environmental Factors (eg. Animal bites, sting) ○
- Fire/Flames or Resulting Fumes ○
- Near Drowning ○
- Other (please specify) ○ ____________________

5. Where did the incident occur?

- Inside of your home/apartment? ○
- Outside your home/apartment - including yard, driveway, parking lot or shared areas related to home such as apartment hallway or laundry room ○
- In or around other private residence ○
- Inside school/child care centre or on school/ centre grounds ○
- At an indoor or outdoor sports facility (other than at school) ○
- Other building used by general public ○
- On sidewalks/street/highway in your neighbourhood ○
- On any other sidewalks/street/highway ○
- In a playground/park (other than school) ○
- Other (please specify) ○ ____________________

SECTION C: CHILD SAFETY

	Never	Sometimes	Most of the time	Always	Not Applicable
1. When traveling in the car, how often does your child					
a) use a car or booster seat?	○	○	○	○	○
b) ride in the front passenger seat?	○	○	○	○	○
2. How often does your child wear a helmet					
a) while riding a bicycle or tricycle?	○	○	○	○	○
b) while riding a scooter or skateboard?	○	○	○	○	○

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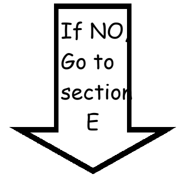
SECTION D: CHILD CARE

1. Prior to your child starting senior kindergarten did he/she **ever** receive child care on a regular basis (at least once a week) from someone other than a parent? Do not include the occasional use of babysitters.

Yes	No
○	○



For the next few questions, we are interested in the characteristics of the PRIMARY or MAIN child care arrangement you had during certain age periods.

2. Who took care of your child in your **PRIMARY** child care arrangement? *If your child was NOT in regular child care during a certain age period, mark the **NO Child Care** column.*

Age of Child	NO Child Care	Relative	Non-relative who is NOT an Early Childhood Educator	Non-relative who IS an Early Childhood Educator (at least a College diploma)
0 to 6 months	○	○	○	○
7 months up to 2 yrs	○	○	○	○
2 yrs up to 4 yrs	○	○	○	○
4 yrs up to 6 yrs	○	○	○	○

3. Where was your PRIMARY child care arrangement located? *If your child was NOT in regular child care during a certain age period, mark the **NO Child Care** column.*

Age of Child	NO Child Care	Child's Home	Other's Home	Child Care Centre
0 to 6 months	○	○	○	○
7 months up to 2 yrs	○	○	○	○
2 yrs up to 4 yrs	○	○	○	○
4 yrs up to 6 yrs	○	○	○	○

4. Overall, how satisfied were you with the care your child received in your **PRIMARY** child care arrangement? *If your child was NOT in regular child care during a certain age period, mark the **NO Child Care** column.*

Age of Child	NO Child Care	Not at All Satisfied	Somewhat Satisfied	Satisfied
0 to 6 months	○	○	○	○
7 months up to 2 yrs	○	○	○	○
2 yrs up to 4 yrs	○	○	○	○
4 yrs up to 6 yrs	○	○	○	○

5. On average, how many total hours per week did your child typically spend in child care?

Age of Child	0 Hours	Less than 20 Hours/Wk	21-40 Hours/Wk	More than 40 Hours per Wk
0 to 6 months	○	○	○	○
7 months up to 2 yrs	○	○	○	○
2 yrs up to 4 yrs	○	○	○	○
4 yrs up to 6 yrs	○	○	○	○

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6. How many different child care arrangements did you have for your child during each of the following age periods?

Age of Child	0	1-2	3-5	More than 6
0 to 6 months	○	○	○	○
7 months up to 2 yrs	○	○	○	○
2 yrs up to 4 yrs	○	○	○	○
4 yrs up to 6 yrs	○	○	○	○

SECTION E: PRE-KINDERGARTEN

1. Below is a list of programs in which young children and their parents/caregivers participate. Indicate if your child has participated in the past year and if they **EVER** participated in any activities listed below. **(MARK ALL THAT APPLY).**

	Past Year	Ever
Play-based children's programs where both child and parent/caregiver attend together *(e.g., drop-ins, Mom's and Tots programs, Ontario Early Years Centre programs, Family Resource Centre programs)*	○	○
Family reading programs *(e.g., library storytimes, All-star reading)*	○	○
Programs or services for English as a second language	○	○
Resource lending *(e.g., toys, books, kits)*	○	○
Organized team sports *(e.g., hockey, soccer, baseball, lacrosse)*	○	○
Physical activity programs *(e.g., swimming & skating lessons, gymnastics, Sport Ball)*	○	○
Recreational programs (e.g., family swimming & skating)	○	○
Dance	○	○
Music programs for children	○	○
Arts for children *(e.g., drama, crafts)*	○	○
Faith-related programs for children	○	○

2. Below is a list of programs and services for young children. Indicate if your child has participated in the **PAST YEAR** and if they **EVER** participated in any of the following. **(MARK ALL THAT APPLY)**

	Past Year	Ever
Speech and language programs	○	○
Programs or services for the visually impaired	○	○
Occupational therapy and/or physiotherapy	○	○
Programs or services for the developmentally delayed	○	○
Programs or services for treatment of behavioral problems	○	○
Other (please specify) ______________________________	○	○

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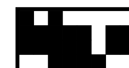

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SECTION F: SENIOR KINDERGARTEN

	Full Day/Alternate	Half-Day/Every Day
1. The kindergarten program that your child attends is:	○	○

2. Indicate your level of agreement for each of the following statements.	Strongly Disagree	Disagree	Agree	Strongly Agree	Don't Know
My child enjoys going to school	○	○	○	○	○
The kindergarten schedule meets the needs of MY CHILD	○	○	○	○	○
The kindergarten schedule meets the needs of OUR FAMILY	○	○	○	○	○
I feel my child is able to manage the school day	○	○	○	○	○
Overall, I am satisfied with the kindergarten program	○	○	○	○	○

3. How important were each of the following events or resources to your child starting kindergarten?	Not Important	Somewhat Important	Important	Very Important	Don't Know
Spring parent orientation evening	○	○	○	○	○
Kindergarten year "At a Glance" calendar	○	○	○	○	○
Summer kindergarten calendar	○	○	○	○	○
Individual student kindergarten visit	○	○	○	○	○
Fall gradual kindergarten entry	○	○	○	○	○

	None	1-2 School Days	3-5 School Days	6-10 School Days	Don't Know
4. Since September, how many school days has your child been absent from school?	○	○	○	○	○

	Yes	No
5. Did you have **any** difficulties making child-care arrangements for those times when your child was not attending the school kindergarten program?	○	○

SECTION G: YOU AND YOUR CHILD

1. In the **PAST 7 DAYS**, have you or someone close to your child done the following things with your child?	Yes, Many Times	Yes, Once or Twice	NO
Told or read (him/her) a story	○	○	○
Taught (him/her) letters, words, or numbers	○	○	○
Taught (him/her) songs or music	○	○	○
Worked on arts or crafts with him/her	○	○	○
Played a game, sport, or walked together	○	○	○
Took him/her along while doing errands like going to the post office, the bank or grocery store	○	○	○
Involved him/her in household chores like cooking, cleaning, setting the table, or caring for pets	○	○	○

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2. In the **PAST 7 DAYS,** how many hours did your child spend doing the following activities?

	0 Hours	1-5 Hours	6-10 Hours	More than 10 Hours
Played outdoors	○	○	○	○
Used a computer	○	○	○	○
Watched television/movie by him/herself	○	○	○	○
Watched television/movie together with an adult	○	○	○	○

SECTION H: COMBINING WORK AND FAMILY

	Not Currently Employed	Less than 10 hours	10-25 Hours	26-34 Hours	35- 40 Hours	41-50 Hours	More than 50 Hours
1. In a typical week, how many total hours (including overtime) do you work for pay?	○	○	○	○	○	○	○
2. In a typical week, how many total hours (including overtime) would your partner work for pay? Leave blank if you don't have a partner.	○	○	○	○	○	○	○

3. Please indicate if your (or your partner's) workplace offers the following

	Support offered?		
	Yes	No	Don't Know
a. Alternate work arrangements (e.g., flex time, part-time positions, compressed work week, job-sharing, work-at-home)	○	○	○
b. Child Care Centre	○	○	○
c. Subsidized child care benefits - workplace pays a portion of your child care	○	○	○
d. Parenting courses or workshops offered at the workplace during work or lunch	○	○	○
e. Parenting information (books, videos, brochures)	○	○	○

SECTION I: YOUR NEIGHBOURHOOD

	Less than One Year	1-4 years	5-10 years	More than 10 Years
1. How many years have you lived at your current address?	○	○	○	○

	Excellent	Good	Average	Poor	Very Poor
2. How do you feel about your neighbourhood as a safe place to bring up children? Is it...	○	○	○	○	○

3. In the past 12 months, how often have you participated in the following activities

	At least once a week	At least once a month	At least 3 or 4 times a year	At least once a year	Not at all
a. Volunteer work including school groups, church groups, community or ethnic associations	○	○	○	○	○
b. Religious services or meetings (not including special occasions such as weddings or funerals)	○	○	○	○	○
c. Going to a neighbourhood park with your child	○	○	○	○	○

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SECTION J: BACKGROUND INFORMATION

To help us understand the families who are participating in this study, we would like to ask a few questions about yourself, your family and your household.

1. Are you the child's: ○ Mother ○ Father ○ Other (please specify) ____________

	English	French	Other (please specify)	
2. What language do you speak most often at home?	○	○	○	____________
3. What language does your child speak most often at home?	○	○	○	____________

	Less than $30,000	$30,001 to $50,000	$50,001 to $75,000	$75,001 to $100,000	Greater than $100,000
4. What is your total household income?	○	○	○	○	○

5. What is your highest level of education? (mark only one)

- Did not complete High School ○
- Completed High School ○
- College diploma or Trades Certificate ○
- University Undergraduate Degree ○
- University Graduate Degree ○

6. Does anyone in your household smoke? ○ Yes ○ No

	Excellent	Good	Average	Poor	Very Poor
7. In general, would you say your health is:	○	○	○	○	○

	Single	Married	Common-Law	Separated	Divorced	Widowed
8. What is your current marital status?	○	○	○	○	○	○

9. In addition to your child, who else lives in your household on a regular basis? (overnight stays at least once a week) **(Mark all that apply).**

Mother	○	Step parent	○	Other Relatives (aunts, uncles, cousins)	○
Father	○	Step Sibling(s)	○	Unrelated Adult(s)	○
Sibling (s)	○	Grand Parents	○	Unrelated Child(ren)	○

10. How many people live in your household on a regular basis *(overnight stays at least once a week)*

☐ Number of Children ☐ Number of Adults

11. Have you ever attended

	Yes	No
a. Pre-natal class for expectant parents	○	○
b. Parenting class, workshop or program	○	○

THANK YOU FOR YOUR PARTICIPATION!

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