Kindergarten Health Survey

DEAR PARENT OR GUARDIAN: *This survey has been designed by the Nevada Institute for Children's Research and Policy at the University of Nevada Las Vegas, in partnership with the State of Nevada Department of Health and Human Services, and the local county school districts. The information from this survey will be used to help understand the health of children entering kindergarten this year. You have been asked to participate because you have a child entering kindergarten.* ***Your responses to this survey will be confidential.*** *All information from this survey will be used to discuss children's health on a group level, not on an individual.*

Name of elementary school: ____________________

Your HOME zip code: ___________

Do you ☐ Rent your home or ☐ Own your home

Are you a single parent/guardian? ☐ Yes ☐ No

Total # of **children**(0-17) in your household: _______
Total # of **adults** in your household (18+): ________

Age of child's mother/guardian: ______
Age of child's father/guardian: _______

Annual household Income: (check one)
☐ $0 -$14,999
☐ $15,000 -$24,999
☐$25,000 -$34,999
☐ $35,000 -$44,999
☐ $45,000 -$54,999
☐ $55,000 -$64,999
☐ $65,000 -$74,999
☐ $75,000 -$84,999
☐ $85,000 -$94,999
☐ $95,000 +

Does anyone in your household smoke? ☐ Yes ☐ No

Is smoking allowed in your house? ☐ Yes ☐ No

Have you experienced any of the following events in the last 12 months? (check all that apply)
☐ Moved to a new home ☐ Birth of a child
☐ Divorce or separation ☐ Death in the family
☐ Loss of a job or income ☐ Serious medical issues in the home
☐ Other household change or major life event:
Explain: ______________________________

Please answer the following questions for the child that will be enrolled in kindergarten this year.

1. Child's age: _________

2. Child's gender: ☐ Male ☐ Female ☐ Other

3. Child's weight: _______ pounds

4. Child's height: _____ ft. _____ in. (12in = 1ft)

5. Child's race / ethnicity:
☐ African American/Black ☐ Hispanic / Latino
☐ Asian / Pacific Islander ☐ Native American / Alaska Native
☐ Caucasian/White ☐ Other (please specify): ___________________

6. Please select the type of medical insurance your child currently has: (Check all that apply)
☐ None/Uninsured ☐ Private (Employer/Union)
☐ Medicaid ☐Nevada Check-Up
☐Other____________

7. Have you or someone else:
Applied for Medicaid or other health plan for **your child** through the Silver State Exchange/NV Health Link? ☐Yes ☐No ☐Not Sure
If yes, was your child approved? ☐Yes ☐No ☐Not Sure

8. Does your child have a primary care provider (regular doctor, nurse practitioner, or physician's assistant)?
☐Yes ☐No

9. In the *past 12 months* has your child visited a:
Medical provider for a routine check-up (not an illness)? ☐Yes ☐No
Dentist? ☐Yes ☐No

10. Please select any medical conditions listed below that your child has: (Check all that apply) ☐ None
☐ADD / ADHD ☐ Glasses / Contacts
☐ Allergies ☐Hearing Aid / Impairment
☐Asthma ☐Mental Health Condition
☐ Autism ☐Physical Disability
☐Cancer ☐Seizures
☐Diabetes ☐Other (specify) _________________

11. Please check which one best describes what your child drank ***at each time point***:

	Breast Only	Breast & Formula	Formula Only	Other (e.g. food)	Not Sure
1 Month (check one)	☐	☐	☐	☐	☐
3 Months (check one)	☐	☐	☐	☐	☐
6 Months (check one)	☐	☐	☐	☐	☐
12 Months (check one)	☐	☐	☐	☐	☐

List barriers to breastfeeding: ___________________________________

12. Has your child had a developmental screening (like the Ages and Stages Questionnaire) in the past 12 months?
☐ Yes ☐No ☐Not sure

13. Do you know where or how to access support services and programs in your community to meet your child's/family's needs? (e.g.food/bills, parent classes, support groups, etc.)
☐Yes ☐Somewhat ☐ No

14. Please select any barriers you have experienced when accessing health care for your child: (check all that apply)
☐None ☐Lack of transportation
☐Lack of insurance ☐Lack of good medical providers
☐Lack of money ☐Other (specify): ____________

15. Have you ever tried to get mental or behavioral health services for your child? ☐Yes ☐ No
If yes, have you had trouble getting services?
☐No ☐Yes (explain) _________________________

16. In general, how many days a week does your child do at least 60 minutes of physical activity? (circle one)
0 1 2 3 4 5 6 7
List barriers: ____

17. On an average school day, how many hours does your child watch TV? (circle one)
None Less than one 1 2 3 4 5 +

18. On an average school day, how many hours does your child play video or computer games? (Xbox, Nintendo, tablets, and/or the internet). (circle one)
None Less than one 1 2 3 4 5 +

19. **During the past 7 days**, how many times did your child drink a can, bottle, or glass of…

	None	A few times	Once a Day	More than Once a Day
Non-diet soda or pop (check one)	☐	☐	☐	☐
Diet soda or pop (check one)	☐	☐	☐	☐
Fruit Juice (check one)	☐	☐	☐	☐

20. What type of pre-school did your child attend most often in the *past 12 months*? (check one)
☐ None / Stayed home ☐ Friends/Family/Neighbor care ☐Home-based
☐ School District Pre-school (name) ______________________
☐University Campus Pre-school (name) ___________________
☐ Head Start (name) _______________________________
☐Other Facility/Center (name) __________________________

21. ***On average,*** how many hours per week did your child attend preschool?
☐Zero ☐ 5-10 ☐11-15 ☐16-20 ☐21-30 ☐31-40 ☐More than 40

22. If your child did not attend preschool, what were some reasons? (check all that apply):
☐None, my child went to preschool ☐I wanted to keep them home
☐ Too expensive ☐Location too far ☐ Hours not convenient
☐ Other _____________
If you wanted your child to attend, which would you prefer?
1) (check one) ☐full time ☐ part-time
2) (check one) ☐ home based ☐ facility/center based ☐ School District

PLEASE RETURN THIS SURVEY TO YOUR CHILD'S TEACHER BY OCTOBER 15, 2016

Thank you for your participation. If you are interested in participating in future research, please provide your:

Name:______________________________________ Contact Phone/Email:______________________________________

TEACHERS: Please return the survey to your school's front office, or mail to:
NICRP, Kindergarten Health Survey, 4505 Maryland Parkway, Box 453030, Las Vegas, NV 89154

For Questions/Concerns Contact: Amanda Haboush 702-895-1040 Amanda.Haboush@unlv.edu