

# McMaster University - Kindergarten Parent Survey

Dear Parents and Guardians of Year 1 (JK) and Year 2 (SK) Kindergarten Students,

## We need your feedback!

The Offord Centre for Child Studies at McMaster University, with assistance from the Regional agency and school boards name(s), is conducting a Kindergarten Parent Survey (KPS). You have been asked to participate in this survey because you have a child who is now in year 1 (JK) or 2 (SK) of the kindergarten program.

The attached Kindergarten Parent Survey, developed by the Offord Centre, asks a variety of questions about children's early experiences, health, service and program usage, etc. The results provide information to local children's agencies and organizations to better understand the context in which children live, grow, and learn in their early years and to help guide service planning and work towards improving the well-being of children within your community. The data collected from the survey will be made available to the Regional agency and may be shared with your child's school board. At no time will you the parent/guardian (respondent) or your child be identified.

## What You Need to Know

- **Your responses are voluntary and anonymous** (do not include your name or your child's name on the survey). Your postal code will be used to group your results into neighbourhood boundaries.
- The survey should take approximately **20 minutes to complete**.
- Your completed survey will be submitted to a secure server housed at McMaster University in Hamilton Ontario.
- **Your individual responses will not be shared with your child's teacher or school principal.** Information may be summarized and reported on only at group levels such as community and school board, not by school.
- There are no risks or direct benefits to you or your child for participating. We feel that this information can help answer important questions about factors that affect the early development of children in our community, inform programs and services, and identify barriers and gaps in services.
- The survey results may be used in reports and in future research papers.
- You can contact the McMaster University Research Ethics Board at (905) 521-2100 ext. 23142 if you have any questions about your rights as a research participant.

For more information contact:

Name of Regional Agency representative and contact information



## Section A: Where Do You Live?

**A1. What community do you live in or are closest to?**

**A2. What is your postal code?**

*Postal code should be entered in A1A 1A1 format.*

**A3. What school board does your child's school belong to?**

## Section B: Child Health and Development

Whenever you are asked about "your child", please answer the question based on your child that is currently enrolled in Kindergarten. If you have more than one child in Kindergarten, please fill out this survey for each child separately.

**B1. Is your child in JK or SK?**

Year 1 - JK	Year 2 - SK	I don't know
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**B2. If your child is in SK, did they attend a JK program?**

Yes, at school	Yes, at a location other than school	No, did not attend a JK program	Not applicable
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**B3. What gender is your child?**

Female ☐

Male ☐

Gender non-conforming (please specify)

☐

Gender non-conforming (please specify)



**B4. What is your relationship to this child?**

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**B5. When was your child born?**

*Please use date format: month / day.*

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**B6. Was your child born within 2 weeks of their due date?**

Yes	No	I don't know
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**B7. Does your family have a regular family doctor or health care provider?**

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>

**B8. How many of your children are now in Year 1, junior kindergarten (JK), or Year 2, senior kindergarten (SK)?**

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**B9. Did you or your healthcare provider complete a development checklist (NDDS) for your child during their 18-month doctor's visit?**

*The NDDS (Nipissing District Developmental Screen) is a 17-question checklist designed to help monitor child development.*

Yes	No	My child did not have an 18-month doctor's visit.	I don't know
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**B10. Do you have concerns about your child's:**

*Please choose all that apply.*

Vision ☐

Hearing ☐

Allergies ☐

Dental health ☐

No concerns ☐

Other ☐

Other

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**B11. In the last year, did your child visit a healthcare professional for routine checkups or needles (i.e., immunizations)?**

Yes	No	I don't know
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**B12. In the last year, how was your child's overall health?**

Poor	Fair	Good	Very Good	Excellent	I don't know
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**B13. Does your child have a special health / education need?**

	No	Suspected, but not diagnosed	Yes, diagnosed	I don't know
Health need	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Education need	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**B14.**

**If applicable, please specify which special health/educational needs your child has:**

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**B15. In the last year, how often has your family accessed community food services (e.g. food bank, Community Care)?**

None at all	1 - 3 times	4 - 6 times	More than 6 times
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**B16. Does your child usually go to bed at the same time every day?**

Yes	No	I don't know
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**B17. On a regular week day, how many hours does your child sleep (adding together night time sleep and naps)?**

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**B18. In a regular week, how often does your child eat breakfast?**

Never	Once a week	Several times a week	Daily	I don't know
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**B19. In a regular week, how often does your child eat meals together with the family?**

Never	Once a week	Several times a week	Daily	I don't know
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



**B20.** In the past year, was your child injured seriously enough to require medical attention by a doctor, nurse, or dentist (such as a broken bone, bad cut or burn, head injury, poisoning, or sprained ankle)?

Yes                      No                      I don't know

☐                      ☐                      ☐

**B21. In the past 3 months, has your child experienced any bodily aches or pains that lasted for more than 24 hours?**

Yes                      No                      I don't know

☐                      ☐                      ☐

**B22. Where is, or where was, the pain located? Select all that apply.**

Not applicable	<input type="checkbox"/>
Head	<input type="checkbox"/>
Chest	<input type="checkbox"/>
Neck	<input type="checkbox"/>
Pelvis/Upper leg	<input type="checkbox"/>
Back	<input type="checkbox"/>
Knee/Lower leg	<input type="checkbox"/>
Shoulder/Elbow/Arm	<input type="checkbox"/>
Ankle/Foot/Toes	<input type="checkbox"/>
Wrist/Hand/Fingers	<input type="checkbox"/>
Abdomen/Stomach	<input type="checkbox"/>
I don't know	<input type="checkbox"/>
Other	<input type="checkbox"/>

Other

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**B23. How long has your child had this pain?**

[illegible]

**B24. What has been the impact of the pain your child is, or was, experiencing? For each question select one option.**

	Not applicable	Never	Almost never	Sometimes	Often	Almost always	I don't know
My child has trouble sleeping when he/she has pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My child feels angry when he/she has pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My child has trouble doing school activities when he/she has pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
It is hard for my child to pay attention when he/she has pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
It is hard for my child to run when he/she has pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
It is hard for my child to walk one block when he/she has pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
It is hard for my child to have fun when he/she has pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
It is hard for my child to stay standing when he/she has pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**B25. On a scale of 1 to 10, where 1 is no pain and 10 is the worst possible pain, tell me what number best represents your child's level of pain in the past 2 weeks?**

	1	2	3	4	5	6	7	8	9	10
Level of pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## Section C: Child Care and Pre-Kindergarten Experiences

**C1. What was the total length of the parental leave?**

Under 6 months	6 months - 1 year	Over 1 year	Not applicable
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**C2. Before Kindergarten, has your child ever been cared for by someone other than a parent/guardian on a regular basis? Please don't include occasional babysitting.**

Care by a relative in your own home	<input type="checkbox"/>
Care by a non-relative in your own home	<input type="checkbox"/>
Care by a relative in his/her home	<input type="checkbox"/>
Care by a non-relative in his/her home	<input type="checkbox"/>
Preschool	<input type="checkbox"/>
Daycare/child care centre	<input type="checkbox"/>
No	<input type="checkbox"/>



Other (please specify):

☐

Other (please specify):

**C3. Which care arrangement was used for the longest period of time?**

Not applicable

☐

Care by a relative in your own home

☐

Care by a non-relative in your own home

☐

Care by a relative in his/her home

☐

Care by a non-relative in his/her home

☐

Preschool

☐

Daycare/child care centre

☐

Other

☐

Other

**C4. When this child was born was any parental leave taken by either parent/guardian?**

Yes, both par  
ents/guardi  
ans took  
parental leave

☐

Yes, one  
parent/guardi  
an took  
parental leave

☐

No

☐

Not  
applicable

☐

I don't  
know

☐

**C5. How old was your child when this care arrangement began?**

Age in years

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**C6. On average, how many hours per week was your child in this care arrangement?**

Not  
applicable

☐

8 hours or  
less per  
week

☐

9-15  
hours per  
week

☐

16-30  
hours per  
week

☐

More than  
30 hours  
per week

☐

I don't  
know

☐



**C7. In the year before your child started school, how often did your child attend/visit:**

	Once a week or more	1 - 3 times a month	Several times a year	Once a year	Not at all	I don't know
Play-based child and family programs (e.g. drop-ins, mom and baby programs, Parenting and Family Literacy Centres, Ontario Early Years Centres/EarlyON Centres, Best Start Hubs, Family Resource Centre programs)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Literacy and family reading programs (e.g. story times/circles at public libraries and other local venues, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Music, Arts or Dance programs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A public library	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A bookstore	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Children's culture or ethnic-based programs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Children's language-based programs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Museum	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical activity programs (e.g. swimming, soccer, gymnastics, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**C8. Since birth, has your child needed help from any of the following services?**

	Yes, received	Yes, did not receive	No, not needed	I don't know
Speech and Language Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blind or Low Vision Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Programs/Services for Behavioural Issues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental Health Programs/Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Programs/Services for English as a Second Language	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dental services beyond regular dental care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Special Nutrition Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Learning Support (e.g. help with listening, talking, problem solving)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>





## Section D: Kindergarten

### D1. To what extent do you agree/disagree with the following statements?

	Strongly agree	Agree	Disagree	Strongly disagree	I don't know
My child enjoys going to school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My child is excited about learning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My child has many friends	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My child gets along with others his/her own age	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My child's school is a friendly and welcoming place	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
As a parent, I feel welcome in my child's school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My child's school building is an inviting place to learn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My child feels accepted by adults in his/her school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My child feels safe at school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The kindergarten schedule meets the needs of our family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I feel my child is able to manage the school day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The kindergarten program helps my child's learning and development	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Overall, I am satisfied with the kindergarten program	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### D2. Do you use before or after school care?

Yes, both	Yes, only before school care	Yes, only after school care	No, I don't use either
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### D3. Do you need before or after school care that you currently don't have access to?

Yes, both	Yes, I need before school care	Yes, I need after school care	No, I have access to both	No, I don't need either	I'm not aware of these programs/services
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### D4. Has the school expressed concerns about the child's behaviour or learning?

No	Yes, concerns about behaviour	Yes, concerns about learning	Yes, both	I don't know
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### D5. Are there barriers for you being more involved in school activities?

I've never been asked to come ☐

Times don't work for me/conflict with work ☐



Don't have a way to get there ☐

Hard to get child care for my other children ☐

Don't know about the activities ☐

Health issue or disability ☐

Don't know other parents in the school ☐

Don't know teacher, early childhood educator, or school staff well ☐

Language barrier ☐

Hassle/need for a police check ☐

Not applicable ☐

Other ☐

Other

## Section E: You and Your Child

**E1. Check the statements below that you as a parent find challenging:**

Finding family time ☐

Getting your child ready for school ☐

Playing with your child ☐

Preparing healthy meals ☐

Getting your child to eat healthy ☐

Motivating your child to be physically active ☐

Having enough food for your family ☐

Being aware of what children should or could be doing at a given age ☐

Assisting your child in transitioning from one form of care to another, or from one program to another during the day ☐

Use of drugs, alcohol, or gambling in the family ☐



Dealing with a grandparent's poor health (mental, physical) ☐

Making ends meet (e.g. finances) ☐

None of the above ☐

Other ☐

Other

**E2. How often have you had the chance to talk to your child about:**

	Most days	A few times a week	Once a week	A few times a month	Less than once a month	Not yet
Their positive interactions with other children (e.g. a recent experience sharing with or helping another child)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Their negative interactions with other children (e.g. a recent experience of fighting with another child or feeling excluded)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Their emotions or feelings?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Your emotions or feelings?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Others' emotions or feelings (e.g. another child or adult)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**E3. In general, how many days of the week do YOU participate in moderate to vigorous physical activity for at least 30 minutes?**

None	1 - 2	3 - 4	5 or more
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**E4. Including all household members and regular visitors, does anyone smoke inside your home, every day or almost every day?**

*Includes cigarettes, cigars, and pipes. Smoking inside your home excludes smoking inside the garage, whether attached or detached.*

No	Yes
<input type="checkbox"/>	<input type="checkbox"/>

**E5. Over the last year, how often has your child played a sport or done physical activities with and without a coach or instructor outside of gym class?**

	Once a week or more	1 - 3 times a month	Several times a year	Once a year	Not at all
With a coach or instructor (e.g., swimming lessons, baseball, hockey, dance etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Without a coach or instructor (e.g., biking, skate-boarding, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



**E6. In the past 7 days have you (or someone close to your child) done any of the following activities with your child not during school time:**

	Yes, every day	Yes, three or more days	Yes, one or two days	No
Played simple math games (e.g. cards, counting, puzzles, board games)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sang songs or said rhymes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Told or read him/her a story	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Helped with arts, crafts, or drawing with him/her	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Helped with the sounds of letters	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Helped with printing letters, numbers, or child's name	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Done household chores together (e.g. cleaning, putting away toys, caring for pets)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gone on an outing together (e.g. shopping, done errands)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Participated in physical activity/family activities (e.g. walk, ride bike, play outside)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Talked together about your child's day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Played together (e.g. hide and seek, tag, dress-up, tea party)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**E7. In a regular week (7 days), how many hours per day does your child spend ALONE playing video games or watching programs/movies on an electronic device (e.g., TV, tablet, computer, cellphone)?**

None	Less than 1 hour per day	1 - 2 hours per day	2 - 3 hours per day	3 - 4 hours per day	More than 4 hours per day	I don't know
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**E8. In a regular week (7 days), how many hours per day does your child spend WITH OTHERS playing video games or watching programs/movies on an electronic device (e.g., TV, tablet, computer, cellphone)?**

None	Less than 1 hour per day	1 - 2 hours per day	2 - 3 hours per day	3 - 4 hours per day	More than 4 hours per day	I don't know
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## Section F: Your Neighbourhood/Community

**F1. Do you live in a rural or urban community?**

Rural	Urban	I don't know
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



**F2. Do you have access to the following places near your home? Access might mean walking, driving your car a short distance, or taking the bus.**

	Yes	No	I don't know
Public park or athletic field	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Library	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Community centre	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
School	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Grocery store	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cultural centre	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Faith centre	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Swimming pools, splash pad, or water playground	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arena	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Family or family-like friends	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**F3. Please tell us about where you live:**

	True	Sometimes true	Not true	I don't know
It is safe to walk alone after dark	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
It is safe for children to play outside during the day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
There are safe parks, playgrounds, and play spaces	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If there is a problem around here, the neighbours get together and deal with it	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
There are adults in my community that children can look up to	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
People around here are willing to help their neighbours	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
You can count on adults in my community to watch out that children are safe and don't get into trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I know my neighbours	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My community is child friendly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>





**G7. What language(s) does your child speak most often at home?**

First language

--	--	--	--	--	--	--	--	--	--

Second language (if applicable)

--	--	--	--	--	--	--	--	--	--

Third language (if applicable)

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**G8. Does your child self-identify as Indigenous (First Nations, Métis, or Inuit)?**

Yes	No	I don't know
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**G9. If applicable, please indicate the Indigenous Nation(s) and language(s) your child identifies with.**

Indigenous Nation(s):

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Indigenous Language(s):

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**G10. Was your child born in Canada?**

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>

**G11. If your child was not born in Canada:**

In what country was your child born?

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What year did they come to Canada?

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**G12. Were you born in Canada?**

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>

**G13. If you were not born in Canada:**

In what country were you born?

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What year did you come to Canada?

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**G14. In the last 5 years, how often has your child moved to a different home?**

Never	Once	Twice	3 times	4 times	5 or more times	I don't know
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**G15. Which of the following best describes YOUR highest educational level?**

Did not complete high school	Completed high school	College diploma or trades certificate	Undergraduate degree	Graduate degree
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>




**G16. What is YOUR main employment status?**

Working for pay (full-time) ☐Working for pay (part-time) ☐On parental leave ☐Caring for family/homemaking ☐Student 

Recovering from illness/on disability	
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Unemployed and looking for work	
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Retired

Other 

Other

**G17. In a regular week, how many hours do YOU spend away from home for work (including your commute)?**

[illegible]

**G18. Which of the following best describes the highest educational level for the child's OTHER PARENT/GUARDIAN (if applicable)?**

		<b>Did not</b>	<b>Completed</b>	College diploma or trades certificate	<b>Undergrad</b>	Graduate	
Not applicable	high school	high school	high school		degree	degree	I don't know
<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>





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Other

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**G20. In a regular week, how many hours does your child's OTHER PARENT/GUARDIAN spend away from home for work (including their commute)?**

Not applicable	Under 25 hours	25 - 49 hours	50+ hours	Work from home full-time	Not currently employed	I don't know
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**G21. What is your household income before taxes?**

Under \$10,000	<input type="checkbox"/>
\$10,000 to \$19,999	<input type="checkbox"/>
\$20,000 to \$29,999	<input type="checkbox"/>
\$30,000 to \$39,999	<input type="checkbox"/>
\$40,000 to \$49,999	<input type="checkbox"/>
\$50,000 to \$59,999	<input type="checkbox"/>
\$60,000 to \$69,999	<input type="checkbox"/>
\$70,000 to \$79,999	<input type="checkbox"/>
\$80,000 to \$89,999	<input type="checkbox"/>
\$90,000 to \$99,999	<input type="checkbox"/>
\$100,000 to \$124,999	<input type="checkbox"/>
\$125,000 to \$149,999	<input type="checkbox"/>
\$150,000 and over	<input type="checkbox"/>
I don't know	<input type="checkbox"/>

**G22. After you pay for necessities (food, housing, hydro, phone, clothes), do you have money left over at the end of the month to buy extra items, to save, or to use in an emergency?**

Never have money left over	Don't often have money left over	Have money left over about half of the time	Often have money left over	Always have money left over	I don't know
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Thank you for taking this survey. Your answers are a valuable part of this research.**