



IN CONFIDENCE

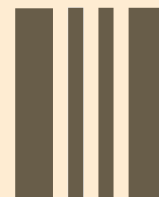
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Study child's name:

Thank you for your ongoing participation in *Growing Up in Australia*, the Longitudinal Study of Australian Children. The study is being run by the Australian Institute of Family Studies on behalf of the Australian Government.

**All information collected will be kept strictly confidential.** Participation in this study is voluntary.



**Please complete this form with regard to the child named above.**

- If your child is in shared care, please answer for the time that your child is with you
- Use **black pen**
- Keep each number or tick within the response box provided, for example

or

- If a mistake is made, please correct it this way

1 Yes     2 No

   5 4 2

- Where appropriate, you can record '0' in the response box. However, do not use 'nil', 'n/a' or '-'
- When you have completed this form, return it in the reply paid envelope (Reply Paid 76746, Sydney NSW 2000)

If you have any questions or want more information, please call **1800 005 508**.

## Your child's schooling

### 1 Is your child currently attending:

- 1 Grade 1/Year 1 or higher (*at school*)
- 2 Prep, kindergarten, transition, reception or pre-primary year (*at school*)
- 3 Preschool (*in your state/territory this may be called kindergarten or pre-prep*)
- 4 Long day care centre (*including early learning program*)
- 5 Not at school, preschool or long day care centre

### 2 Who provides **regular** care for your child when your child is not at (pre)school?

Please tick all the types of care that your child receives.

- 1 I do
- 2 My spouse/partner who lives with me
- 3 Before or after school care **at a school**
- 4 Child care centre, or outside school hours care centre not at school
- 5 Family Day Care provider
- 6 Occasional care centre (*e.g. gym, leisure or community centre*)
- 7 Maternal grandparent
- 8 Paternal grandparent
- 9 Parent who lives elsewhere
- 10 Other relative 18 years and over (*including siblings*)
- 11 Other person 18 years and over (*e.g. nanny, friend, neighbour*)
- 12 Relative under 18 years (*including siblings*)
- 13 Other person under 18 years
- 14 Child cares for self

### 3 How many hours of **regular** care does your child have in an average week?

- **Exclude** care by yourself and your spouse/partner
- **Include** hours at preschool if your child has not yet started full-time school

1 No child care or preschool  hours

### 4 On average, about how many minutes per day is your child doing reading activities at home either with an adult or by himself/herself? Do not include writing activities.

minutes

If your child is NOT attending school or preschool, go to Question 19.

### 5 Since your child started (pre)school this year, how often has he/she appeared to look forward to going to (pre)school?

- 1 Every day
- 2 Most days
- 3 At least once a week
- 4 At least once a month
- 5 Rarely or not at all

### 6 Since your child started (pre)school this year, how often has he/she appeared upset or reluctant to go to (pre)school?

- 1 Every day
- 2 Most days
- 3 At least once a week
- 4 At least once a month
- 5 Rarely or not at all

### 7 How much does your child like his/her teacher(s)?

- 1 A lot
- 2 Quite a bit
- 3 A little
- 4 Not at all

<b>8</b> How well does your child's teacher or (pre)school let you know about your child's progress and behaviour in the class?	Very well	Well	Just OK	Not done at all
	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
<b>9</b> How well does your child generally get along with other children at his/her (pre)school?	Very well	Well	Just OK	Unsure
	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
<b>10</b> How satisfied are you with the quality of education your child receives?	Very satisfied	Satisfied	Dissatisfied	Very dissatisfied
	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
<b>11</b> How much do you agree with each of the following?	Strongly agree	Agree	Disagree	Strongly disagree
(a) I feel welcome when visiting my child's (pre)school	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
(b) I feel that my child's teacher cares about my child	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
(c) I am comfortable talking to my child's teacher about my child	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
(d) I know how to help my child do well in (pre)school	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
<b>12</b> Since the beginning of the (pre)school year, how often have you or another adult in the household...	Very often	Often	Occasionally	Never
(a) Visited your child's class	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
(b) Contacted your child's teacher	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
(c) Talked to parents of other children	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
(d) Attended a school event in which your child participated (e.g. sporting event, musical performance)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
(e) Volunteered in your child's class or helped with a class excursion	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
(f) Attended a meeting of a parent-school committee	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
(g) Attended an individual parent-teacher meeting	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
<b>13</b> During the school term, about how many days a week does your child mainly...	To (pre)school		From (pre)school	
(a) Walk	<input type="checkbox"/> days per week	<input type="checkbox"/> days per week		
(b) Ride a bike or scooter	<input type="checkbox"/> days per week	<input type="checkbox"/> days per week		
(c) Take public transport	<input type="checkbox"/> days per week	<input type="checkbox"/> days per week		
(d) Go by car	<input type="checkbox"/> days per week	<input type="checkbox"/> days per week		

- 14** About how far is it, to the nearest kilometre, from your home to your child's (pre)school?  
Please write your best guess, if unsure.

<sub>1</sub> Less than 1 kilometre   km

**If your child is in preschool, go to Question 19.**

- 15** How often do you or another adult in your household provide help to your child with activities given by their teacher, such as reading?

<sub>1</sub> Daily  
 <sub>2</sub> A few times a week  
 <sub>3</sub> Once a week  
 <sub>4</sub> Less often  
 <sub>5</sub> Child does not have any activities

- 16** We'd like to know about the experiences your child had before starting school. Did your child... (Tick all that apply)

<sub>1</sub> Visit the school informally when collecting older siblings or friends  
 <sub>2</sub> Visit the school with his/her preschool/childcare class  
 <sub>3</sub> Visit the school open day or other function  
 <sub>4</sub> Attend an orientation program at the school  
 <sub>5</sub> Have a buddy from the school during a visit  
 <sub>6</sub> Meet the class teacher before starting school  
 <sub>7</sub> Please tick this if none of the above happened

- 17** Before your child started full-time school, did you or your child's other parent... (Tick all that apply)

<sub>1</sub> Attend a parent orientation session at the school  
 <sub>2</sub> Receive a mail-out information package from the school  
 <sub>3</sub> Receive a phone call from the school  
 <sub>4</sub> Meet the principal or the class teacher  
 <sub>5</sub> Please tick this if none of the above happened

- 18** Overall, how do you think the transition to school went for your child?

<sub>1</sub> Very easy  
 <sub>2</sub> Fairly easy  
 <sub>3</sub> Fairly difficult  
 <sub>4</sub> Very difficult

### Your child's health

- 19** In general, how would you say your child's current health is?

<sub>1</sub> Excellent  
 <sub>2</sub> Very good  
 <sub>3</sub> Good  
 <sub>4</sub> Fair  
 <sub>5</sub> Poor

- 20** Do you have any concerns about...

**(a) How your child behaves**

<sub>1</sub> No  <sub>2</sub> Yes  <sub>3</sub> A little

**(b) How your child gets along with others**

<sub>1</sub> No  <sub>2</sub> Yes  <sub>3</sub> A little

**(c) How your child is learning to do things for himself/herself**

<sub>1</sub> No  <sub>2</sub> Yes  <sub>3</sub> A little

**(d) How your child is learning (pre)school skills**

<sub>1</sub> No  <sub>2</sub> Yes  <sub>3</sub> A little

- 21** How often in the last 6 months has your child accidentally wet his/her pants during the daytime?

<sub>1</sub> Never  
 <sub>2</sub> Rarely  
 <sub>3</sub> Up to once per month  
 <sub>4</sub> Up to once per week  
 <sub>5</sub> Most days

- 22** In the last 12 months, how many times did your child need medical attention from a doctor or hospital because he/she was hurt or injured?

<sub>1</sub> None   times

**23** How much is your child's sleeping pattern or habits a problem for you?

- 1 A large problem
- 2 A moderate problem
- 3 A small problem
- 4 No problem at all

**24** Does your child go to bed at a regular time?

- 1 Always
- 2 Usually
- 3 Sometimes
- 4 Rarely
- 5 Never

**25** On a school night, about what time does your child usually...

	Hours	Minutes
Go to bed	<input type="text"/>	<input type="text"/>
Fall asleep	<input type="text"/>	<input type="text"/>
Wake up in the morning	<input type="text"/>	<input type="text"/>

**26** On a non-school night, about what time does your child usually...

Go to bed	<input type="text"/>	<input type="text"/>
Fall asleep	<input type="text"/>	<input type="text"/>
Wake up in the morning	<input type="text"/>	<input type="text"/>

**27** Does your child have any of these problems on 4 or more nights a week, that is, more than half the time?

- 1 Wheezing or asthma
- 2 Snoring or difficulty breathing
- 3 Difficulty getting off to sleep at night
- 4 Not happy to sleep alone
- 5 Waking during the night
- 6 Restless sleep
- 7 Seeming tired in the morning
- 8 **Please tick this** if none of the above happened

**28** In the last 12 months, have any of the following happened to you (or your current spouse/partner)? (Tick all that apply)

- 1 Birth of a child/pregnancy
- 2 Suffered a serious illness, injury or assault
- 3 A serious illness, injury or assault happened to a close relative
- 4 A parent, partner or child died
- 5 A close family friend or another relative (*aunt, cousin, grandparent*) died
- 6 Separated from a partner/spouse
- 7 Broke off a steady romantic relationship
- 8 Started living with a new partner/spouse
- 9 Had someone new (*other than a new baby, or partner*) move into the household (*e.g. new step or foster child, other relative, friend or boarder*)
- 10 Had a serious problem with a close friend, neighbour or family member
- 11 Had a major financial crisis
- 12 Had a crisis or serious disappointment in your work career
- 13 Thought you would soon lose your job
- 14 Lost your job, but not from choice (*e.g. sacked, redundant, contract ended*)
- 15 Were seeking work unsuccessfully for more than one month
- 16 Had problems with the police or a court appearance
- 17 Something you valued was lost or stolen
- 18 Someone in your household had an alcohol or drug problem
- 19 Changed jobs or returned to work
- 20 Increased work hours
- 21 Decreased work hours
- 22 Moved house
- 23 Been away from home a lot
- 24 Lived in a drought-affected area
- 25 Your home or local area was affected by bushfire, flooding or a severe storm
- 26 **Please tick this** if none of the above happened

## Your child's use of media and technology in your home

**29** Which of the following does your child have access to at your home?

	In his/her bedroom	In the rest of your home	None at home
(a) Television	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
(b) Pay TV (e.g. Foxtel, Austar, Optus, TransACT)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
(c) DVD players	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
(d) Video, DVD or hard-drive recorder to record TV programs	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
(e) Computer/laptop	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
(f) Internet	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
(g) Electronic games systems (e.g. Gameboy, Nintendo, Playstation, X-box, Wii)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3

**30** About how many hours per week does your child spend doing each of the following at home?

Round to nearest hour or half hour (.5), e.g. 2.0, 2.5

	Total time Mon to Fri	Total time Sat and Sun	Does not apply
(a) Watching television programs (including free-to-air and pay TV)	<input type="text"/> <input type="text"/> . <input type="text"/> hrs	<input type="text"/> <input type="text"/> . <input type="text"/> hrs	<input type="checkbox"/> 1
(b) Watching DVDs or videos	<input type="text"/> <input type="text"/> . <input type="text"/> hrs	<input type="text"/> <input type="text"/> . <input type="text"/> hrs	<input type="checkbox"/> 2
(c) Using a computer/laptop	<input type="text"/> <input type="text"/> . <input type="text"/> hrs	<input type="text"/> <input type="text"/> . <input type="text"/> hrs	<input type="checkbox"/> 3
(d) Playing with an electronic game system	<input type="text"/> <input type="text"/> . <input type="text"/> hrs	<input type="text"/> <input type="text"/> . <input type="text"/> hrs	<input type="checkbox"/> 4
(e) Listening to music (e.g. CDs, iPod, MP3, etc.)	<input type="text"/> <input type="text"/> . <input type="text"/> hrs	<input type="text"/> <input type="text"/> . <input type="text"/> hrs	<input type="checkbox"/> 5

**31** How often is a TV on...

	Always	Often	Sometimes	Rarely	Never	Does not apply
(a) During meals	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
(b) Even if no one is watching	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6

**32** When using the computer/laptop at your home, how often does your child...

	Often	Sometimes	Rarely	Never	Unsure	Does not apply
(a) Turn on a computer/laptop by themselves	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
(b) Use a mouse to point and click	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
(c) Put a CD/DVD into the computer/laptop	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
(d) Look at websites	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
(e) Ask to go to a particular website	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
(f) Go to a particular website on his/her own	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
(g) Play games	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6

### 33 Thinking about your family, are there rules about...

	Yes	No	Does not apply
(a) What TV programs your child can watch	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
(b) How many hours of TV, videos and DVDs your child can watch	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
(c) When your child watches TV	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
(d) What your child does on the computer/internet	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
(e) How much time your child uses the computer/internet	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3

### 34 How often do you make sure your child follows the rules about...

	All the time	Most of the time	About half the time	Less than half the time	Never	Does not apply
(a) TV use	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
(b) Computer use	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6

### 35 When your child is...

	All the time	Most of the time	About half the time	Less than half the time	Never	Does not apply
(a) Watching TV, DVDs or videos, how often is an <b>adult watching</b> with them	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
(b) Playing electronic or computer games, how often is an <b>adult in the room</b> with them	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
(c) Playing electronic or computer games, how often is an <b>adult playing</b> with them	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
(d) Using a computer, how often is an <b>adult helping</b> them	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6

### 36 Overall, how concerned are you about your child's current...

	Not concerned	Fairly concerned	Very concerned	Does not apply
(a) TV watching	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
(b) DVD or video watching	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
(c) Electronic or computer game playing	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
(d) Use of the internet	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4

### 37 How easy do you find managing your child's...

	Very easy	Fairly easy	Fairly difficult	Very difficult	Does not apply
(a) TV watching	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
(b) DVD or video watching	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
(c) Electronic or computer game playing	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
(d) Use of the internet	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

**38** How much do you think your child's food choice and eating habits are influenced by ads he/she sees on TV?

A lot	Somewhat	Only a little	Not at all	Does not apply
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

**39** How often does your child want to buy food or other products they have seen on TV?

Often	Sometimes	Hardly ever	Never	Does not apply
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

**40** Please tell us something about your child that makes you proud.

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.....

**41** Who completed this form?

- 1 Child's mother / female guardian
- 2 Child's father / male guardian
- 3 Someone else

Name: *(please print)*

Signature:

Date:  /  /

Please provide email addresses for any adults living at this address:

**Thank you for taking the time to fill in this form.  
Please return in reply paid envelope supplied.**