PARENT OBSERVATION FORM

Name of Child _____ Birthdate _____

Parent/Guardian: _____

Address _____

Daytime Telephone No. _____

Cell Phone (Father/Guardian): _____

Cell Phone (Mother/Guardian) _____

Occupation (Father/Guardian): _____

(Mother/Guardian) _____

Who lives in household? (Please include grandparents, aunts, uncles, etc.) _____

_____

_____

Brothers (name and ages)		Sisters (names and ages)	
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please answer the questions on this form in the best way that you can. Your answers on this form will help the school staff and will involve you in deciding with the teacher what kind of educational program is best suited for your child.

This questionnaire is confidential and your responses will be shared only with school personnel and only if the information learned will help in planning an educational program for your child.

I. General Health History

Please check any health concern that you or your doctor observed:

____ Asthma	____ Bed wetting	____ Loss of consciousness
____ Indigestion	____ Allergies	____ Chronic ear infections (more than 2 per year)
____ Constipation	____ Serious blows to head	____ Inattention
____ Diarrhea	____ Headaches	____ Overtired or lacking pep
____ Vomiting	____ Nightmares	____ Heart trouble
____ Stomachaches	____ Thumbsucking	____ Hyperactivity
____ Frequent fevers	____ Nail biting	____ Medical problems immediately after birth – Please specify:
____ Sinus trouble	____ Epilepsy (seizures)	_____
____ Nose bleeding	____ Diabetes	____ Fainting

____ Other physical problems (explain): _____

Is this child presently on medication? _____ If yes, please indicate type and purpose of medication : _____

Has child had any significant injuries or hospitalization? _____

Is child "healthy" on day of screening? _____

II. Hearing Assessment

Has this child ever had any ear/hearing examination or treatment? __ yes __ no

When _____ By Whom _____ Results _____

		(Yes)	(No)
A.	Do you suspect any hearing problems?	_____	_____
B.	Does your child:		
1.	Seem to have difficulty hearing?	_____	_____
2.	Turn up the TV louder than other members of the family?	_____	_____
3.	Seem to favor one ear over the other?	_____	_____
4.	Jump or appear to be more startled than others if there is a sudden noise?	_____	_____
5.	Seem to hear you if you talk in a whisper?	_____	_____
6.	Make you talk loudly or repeat frequently?	_____	_____
7.	Become confused in following more than two verbal directions at a time?	_____	_____
8.	Have difficulty remembering things for a long time?	_____	_____
9.	Have difficulty remembering things for a short time?	_____	_____

III. Language Development

At what age did your child first begin to speak? Give approximate age if you do not remember exact age:

First words _____ Two or three words together _____

Sentences _____

Does your child:

1. Stutter? _____ Yes _____ No
2. Have difficulty expressing ideas and concepts ? _____ Yes _____ No

Has your child ever been referred for speech or language services? __ Yes __ No

IV. Visual Assessment

Has this child ever had a vision examination or treatment? _____ Yes _____ No

When _____ By Whom _____ Results _____

		(Yes)	(No)
A.	Do you suspect any vision problems?	_____	_____
B.	Does your child:		
1.	Seem to have difficulty seeing small lines or pictures?	_____	_____
2.	Seem to have a problem seeing things far away?	_____	_____
3.	Squint?	_____	_____
4.	Wear glasses?	_____	_____
5.	Have eyes that turn in?	_____	_____
6.	Have eyes that turn out?	_____	_____
7.	Sit very close to television?	_____	_____
8.	Rub eyes a lot?	_____	_____
9.	Turn head as to use primarily one eye?	_____	_____
10.	Lower one side of the head when looking at others?	_____	_____

V. Motor Development

This child began <u>walking</u> at age (if guess, label as such) Age _____

	(Yes)	(No)
Do you feel your child has adequate large muscle coordination?	_____	_____

Does your child:

1.	Catch a ball thrown to him?	_____	_____
2.	Enjoy physical activities?	_____	_____
3.	Lose balance, trip, and fall more often than normal?	_____	_____
4.	Have difficulty running?	_____	_____

VI. Social Development

Does your child:		(Yes)	(No)
1.	Have regular playmates the same age?	_____	_____
2.	Have difficulty getting along with other children?	_____	_____
3.	Prefer to play with other children instead of alone?	_____	_____
4.	Become easily frustrated?	_____	_____
5.	Cry often?	_____	_____
6.	Have a bad temper?	_____	_____
7.	Enjoy cooperating with others?	_____	_____
8.	Become frequently irritated or moody?	_____	_____
9.	Become upset by changes in routine?	_____	_____
10.	Have difficulty dealing with family stress such as illness, death, or separation?	_____	_____
11.	Demand much individual adult attention?	_____	_____
12.	Accept discipline and limits?	_____	_____

Has the child attended a preschool? ___ Yes ___ No Number of years _____

Does your child know how to read? ___ Yes ___ No

Does your child know how to write? ___ Yes ___ No

VII. Is there any other information that will help us better understand your child?

_____

_____

_____

_____

Before school begins, you will have an opportunity to meet individually with your child's teacher. At that time, you may discuss any concerns or special circumstances regarding your child.

Thank you for your patience in filling out this questionnaire.