Student Information from the Parent/Guardian

General Information

Dear Parent/Guardian of: _____

In order to serve the specific needs of your child, we need your input. Please complete all information requested.

Name of Father: _____ Occupation: _____

Name of Mother:_____ Occupation: _____

Name of Legal Guardian: _____

Do both parents live at home? ☐ Yes ☐ No

Address: _____

Phone: _____ Cell Phone: Mother:_____ Father: _____

Number of natural brothers and sisters:___ Ages: _____

Half brothers and sisters:___ Ages: _____

Step brothers and sisters: ___ Ages: _____

Where is your child in relationship to birth order? _____

List all family/friends residing in the home.

Have any important changes occurred within the family during the past two years?

☐ Moves ☐ Births ☐ Deaths ☐ Illnesses ☐ Separations ☐ Divorce ☐ Job Changes

Do any family members have learning difficulties? If so, please explain. _____

_____

Language Use

First language learned by the student: ____ English ___ Other:_____

Language most frequently used by the student at home: ____ English____Other:_____

Language most frequently used by the parents with student: ____ English____Other:_____

Language most frequently used by adults with each other in the home: ____ English____Other:_____

Language most frequently used by student with siblings: ____ English____Other:_____

Has your child ever been instructed in a language other than English? ____Yes ____ No

If yes, what language? _____ For how long? _____

Health History

Pregnancy and Birth History

Did you have any of the following during this pregnancy? (Please check appropriate answer)

Toxemia	_____ Yes	_____No	_____ Unsure
Prolonged vomiting	_____ Yes	_____No	_____ Unsure
Kidney or bladder infection	_____ Yes	_____No	_____ Unsure
Vaginal spotting or bleeding	_____ Yes	_____No	_____ Unsure
High blood pressure	_____ Yes	_____No	_____ Unsure
German measles	_____ Yes	_____No	_____ Unsure
Other rashes, similar to measles	_____ Yes	_____No	_____ Unsure
Diabetes	_____ Yes	_____No	_____ Unsure
Any type of accident	_____ Yes	_____No	_____ Unsure
X-rays	_____ Yes	_____No	_____ Unsure
Drug or alcohol use	_____ Yes	_____No	_____ Unsure
Prescribed medications	_____ Yes	_____No	_____ Unsure
Other illnesses	_____ Yes	_____No	_____ Unsure

If yes on any item, please explain:_____

Please describe any other problems during pregnancy or delivery: _____

_____

Length of pregnancy:_____ Duration of Labor: _____ Birth Weight of Child:_____

Natural birth or Cesarean birth (circle one)

Please describe any problem the child may have experienced directly after birth:

_____

What treatment was given for this problem?_____

Any lasting effects of the problem? _____

Developmental History

At what age did each of the following occur?

Held head up: _____ Held and drank from a cup: _____ Sat alone: _____

Fed self with spoon _____ Crawled: _____ Dressed self: _____
(except shoes)

Walked alone: _____ Toilet Trained: _____

Said single words: _____ Spoke 2 word sentences: _____ Babbled: _____

Do you feel that physical development has been normal?_____

Did you child experience any difficulties with sucking from the bottle or breast?_____

Did you child have any problems eating and/or drinking?_____

Medical History

Has the child had any of the following? (Check ✓ if yes and state age)

Asthma	☐	_____	Kidney Trouble	☐	_____
Poisonings	☐	_____	Heart Trouble	☐	_____
Allergies	☐	_____	Overdose	☐	_____
Tuberculosis	☐	_____	Diabetes	☐	_____
Conclusions	☐	_____	Tubes in Ears	☐	_____
Epileptic Seizures	☐	_____	Head	☐	_____
Visual Problems	☐	_____	Sickle Cell	☐	_____
Pneumonia	☐	_____	Ear Infections	☐	_____
HIV/AIDS	☐	_____	Other: _____		

Comments:_____

_____

Briefly describe serious illnesses, accidents or hospitalizations. Please give your child's age at the time of the illness, accident, or hospitalization:_____

_____

Is the child currently under a doctor's care for any health problem? _____ Yes _____ No

If yes, explain: _____

Is your child now taking any medicines? _____ Yes_____ No If yes, please list medication and what condition it taken for:_____

_____

_____

School History

Has your child mentioned problems with school? _____

Do you think your child has a problem at school? _____

What do you think is causing the problem? _____

Place check (✓) next to any educational problem that your child has currently:

_____ Has difficulty with reading	_____ Has difficulty with math
_____ Has difficulty with writing	_____ Has difficulty with speech/language
_____ Has difficulty with behavior	_____ Other _____

_____ Does not like school: (Explain)_____

_____ Yes _____ No Has your child ever received any Special Education Services? If yes, give dates and types of service._____

_____ Yes _____ No Has your child ever been retained in a grade? If yes, what grades? And why?

_____

Place a check (✓) next to any behavior or problem that your child has currently:

_____ Has noticeable difficulty with speaking.
_____ Has difficulty understanding spoken language.
_____ Is aggressive towards others.
_____ Is more interested in things than in people.
_____ Has behavior that could be dangerous to self and others.
_____ Requires assistance in toileting.
_____ Sucks thumb.
_____ Has special fears or habits (Describe)
_____
_____
_____ Is slow to learn.
_____ Has lost language that was previously observed.
_____ Has frequent nightmares.
_____ Rocks back and forth.
_____ Bangs head.
_____ Holds breath.
_____ Is shy or timid.
_____ Is stubborn
_____ Eats poorly
_____ Has poor bowel control
_____ Is too active.
_____ Is impulsive.
_____ Gives up easily.

What activities does your child participate in at home? *(Check all that apply)*

☐ Watches television ☐ Reads books ☐ Listens to music
☐ Plays electronic games ☐ Plays with others ☐ Spends time on the computer
☐ Participates in sports ☐ Sleeps more than usual ☐ Other _____

What behaviors are frequently displayed by your child at home? *(Check all that apply)*

☐ Is honest ☐ Gets along with others ☐ Throws tantrums
☐ Is helpful ☐ Follows adult requests ☐ Argues
☐ Is responsible ☐ Has mood swings ☐ Disobeys
☐ Respects others ☐ Hits and/or kicks others ☐ Withdraws
☐ Prefers to be alone ☐ Other _____

What methods of discipline are used at home? *(Check all that apply)*

☐ Rewards for good behavior ☐ Assigned responsibilities ☐ Time out
☐ Verbal praise ☐ Early bedtime ☐ Spanking
☐ Special privileges ☐ Removal of privileges ☐ Extra chores
☐ Other _____

How does your child respond to discipline at home? *(Check all that apply)*

☐ Becomes obedient ☐ Throws tantrums ☐ Refuses to obey

☐ Withdraws ☐ Cries ☐ Throws or breaks things

☐ Blames others ☐ Hits and/or kicks ☐ Other_____

What are your child's strengths? _____

_____

_____

What are your child's weaknesses? _____

_____

_____

Are you experiencing any problems with your child at home? _____

_____

_____

Are there any concerns the school needs to be aware of? _____

_____

_____

What suggestions could you give the school to help your child? _____

_____

_____