

Parent Observation Form

NAME OF CHILD _____ BIRTHDATE _____ MALE _____ FEMALE _____
PERSON(S) COMPLETEING FORM _____ RELATIONSHIP TO CHILD _____
FATHER _____ MOTHER _____

Your answers on this form will help the school staff decide with you and teacher what kind of educational program is best suited for your child. Please send this questionnaire to the elementary office prior to the screening date so that we may review this information. This questionnaire is confidential and your responses will be shared only with professional personnel and only if the information learned will help in planning an educational program for your child.

YOUR CHILD'S BIRTH

Child's condition at birth _____ Birth defects _____
Complications _____ Birth weight _____ Length _____
Did the child have any conditions during Infancy, such as jaundice, seizures, breathing problems, etc.
Does your child have a physical disability? _____yes_____no, explain _____

	NO	SOMETIMES	DOESN'T LIKE	LIKES
Scissors _____	_____	_____	_____	_____
Crayons _____	_____	_____	_____	_____
Pencils _____	_____	_____	_____	_____
Playdough _____	_____	_____	_____	_____

YOUR CHILD'S VISION

Has your child's vision been professionally evaluated? _____yes_____no
Results if yes _____
Have you noticed your child's eyes: crossing _____yes_____no
Squinting _____yes_____no
Blinking _____yes_____no

YOUR CHILD'S HEARING

Has your child's hearing been professionally evaluated? _____yes_____no
Has your child's hearing been professionally evaluated? _____yes_____no
Results _____
Has your child had frequent or recurrent infections? _____yes_____no
Does your child have tubes in his/her ears? _____yes_____no
Does your child still have tonsils? _____yes_____no
Does your child listen the TV/radio at the same volume as others in the home? _____yes_____no

YOUR CHILD'S HEALTH

What illness, accidents, or surgeries has your child had? _____
Does your child take any medications regularly? _____yes_____no Medication name _____
Health Concerns: _____

YOUR CHILD'S SPEECH AND LANGUAGE

Do you feel your child has speech problems? _____yes_____no
Describe _____
Is your child's speech understood by unfamiliar people? _____yes_____no

GENERAL INFORMATION

Has your child ever been to daycare or preschool? ____yes____no

How long does your child usually play with toys at one sitting? _____

Does your child take a daily nap? ____yes____no

Does your child have any special fears (i.e. dogs, darkness,etc)? ____yes____no Describe _____

What are the most frequent discipline problems with your child? _____

Is your child presently dealing with family stress such as illness, death, or separation? ____yes____no

Describe _____

YOUR CHILD'S DIET

Does your child have food allergies? ____yes____no Food(s) _____

Reaction _____

Does your child eat or chew things that are not food? ____yes____no Describe _____