

## PARENT INPUT

Student Name:	Date of Birth:	Date:
Home Address:	Home Phone:	
Age:	Grade:	Gender:
		Ethnicity:
Home School:	Attending School:	Student No:
<b>LANGUAGE</b>		
What is the home language (parents, child, family members)?		
What language was learned <b>first</b> by the child?		
Was a second language learned by the child?		
What language does the child speak <b>best</b> ?		
What language(s) does/do the parent(s) speak best?		
At what age did your child first begin to learn English actively (from parents, preschool, school, etc.)?		
If your child was born outside of the United States, at what age did they enter the country?		

The following questions concern your child's development and functioning within your family. The information will be useful in understanding factors which have had an influence on your child's growth and achievement in school, and may be part of comprehensive evaluation. The information provided will be confidential and only used for educational purposes according to FERPA, IDEA, and District guidelines.

**Current Parents/Guardian** (please circle the **B**(irth), **S**(tep), **A**(doptive), **F**(oster). (**G**uardian)

Father: <b>(B)</b> <b>(S)</b> <b>(A)</b> <b>(F)</b> <b>(G)</b>	Phone:	Mother: <b>(B)</b> <b>(S)</b> <b>(A)</b> <b>(F)</b> <b>(G)</b>	Phone:
Name:		Name:	
	E-Mail:		E-Mail:
Address (if different from above):		Address (if different from above):	

<b>Father:</b>	Raised in what city and state or country?
Father's Level of Education (highest grade, years of college, or degree completed):	
Father's Health Problems:	Father's Occupation:
<b>Mother:</b>	Raised in what city and state or country?
Mother's Level of Education (highest grade, years of college, or degree completed):	
Mother's Health Problems:	Mother's Occupation:
<b>(B)(S)(A)(F)(G) Parent:</b>	Raised in what city and state or country?
Parent's Level of Education (highest grade, years of college, or degree completed):	
Parent's Health Problems:	Parent's Occupation:

Please list the names and ages of **ALL** people living in the home and their relationship to the child.

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

If the family is either a single parent or a step configuration, how many years of the child's life have been with two parental figures in the home? \_\_\_\_\_

If the family is either a single parent or a step configuration, how many years of the child's life was there a single parent in the home? \_\_\_\_\_

If the child comes from a home other than both natural parents, what type of relationship do they have with the parent no longer in the home? \_\_\_\_\_

If a birth parent is no longer in the home, how often do they have contact? \_\_\_\_\_

**Please check if either of this child's natural parents, or immediate family members, experienced any of the following which could have contributed to your child's school difficulties:**

- |   |   |
|---|---|
| <input type="checkbox"/> alcohol addiction                    | <input type="checkbox"/> psychological/psychiatric evaluation |
| <input type="checkbox"/> drug addiction                       | <input type="checkbox"/> seizures                             |
| <input type="checkbox"/> learning disabilities/problems       | <input type="checkbox"/> speech or language disorder          |
| <input type="checkbox"/> mental illness                       | <input type="checkbox"/> violence/abuse                       |
| <input type="checkbox"/> intellectual disability              | <input type="checkbox"/> physical disability                  |
| <input type="checkbox"/> other special education disabilities | <input type="checkbox"/> other                                |

Please explain any checked boxes:

**Education Information**

What is your understanding as to why your child is being referred for a possible evaluation?

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What concerns do you have about your child's education?

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Has your child ever received Special Education services or Early Childhood Intervention Programming such as Head Start? Where? When?

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Has your child ever been retained? If so, in what grade? Where?

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How has your child's school attendance been? Few Absences, Some Absences, Frequent Absences, Many Absences?

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Has your child had periods of time when they have been out of / missed school during the school year?

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Please list **ALL** of the schools (with grade level) your child has attended.

<hr/>	<hr/>
<hr/>	<hr/>
<hr/>	<hr/>
<hr/>	<hr/>
<hr/>	<hr/>

Does your child frequently spend time in another city or country? Is so, where do they go and for how long?

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**Medical / Development / Health Information**

**Prenatal / Delivery History**

Mother's age at child's birth: \_\_\_\_\_

Length of pregnancy: \_\_\_\_\_ weeks

Length of labor: \_\_\_\_\_ hours

Birth Weight: \_\_\_\_\_ lbs. \_\_\_\_\_ oz.

Yes  No Did the mother visit the doctor regularly during the pregnancy?

**Pregnancy** (please clarify any "yes" response on the lines below)

Yes  No Was there any difficulty during the pregnancy?

Yes  No Did the mother take medication during pregnancy?

Yes  No Did the mother receive anesthesia during delivery?

Yes  No Did the mother smoke during pregnancy?

Yes  No Did the mother use alcohol during pregnancy?

Yes  No Did the mother use drugs during pregnancy?

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**Birth** (please clarify any "yes" response on the lines below)

Yes  No Was your child born by C-section?

Yes  No Was there any difficulty during delivery?

Yes  No Were there any complications during delivery? (cyanosis, meconium, cord compression, etc.)

Yes  No Was there any trauma to infant? (lack of oxygen, life support, heart problems, etc.)

Yes  No Were there any noted birth defects?

Yes  No Was your child jaundiced?

Yes  No Did your child stay in the hospital longer than the mother?

Yes  No Was there any use of a life support system?

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**Prenatal / Delivery History (continued)**

**Infancy** (please clarify any “yes” response on the lines below)

- Yes  No Any difficulties during infancy?
  - Yes  No Were there any episodes of seizures?
  - Yes  No Was there any Anoxia (lack of oxygen)?
  - Yes  No Did your child have difficulty gaining weight during the first year of life?
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**Developmental Milestones** (check the approximate age when your child did each task)

- Rolling over by self  before 2 months  3-6 months  after 6 months
  - Sitting without support  before 5 months  5-8 months  after 8 months
  - Crawling on hands/knees  before 6 months  6-9 months  after 9 months
  - Walking independently  before 10 months  10-18 months  after 18 months
  - Saying first words  before 12 months  12-18 months  after 18 months
  - Talking in simple 2-3 word sentences  before 24 months  24-36 months  after 36 months
  - Toilet training began  before 24 months  24-40 months  after 40 months
  - Toilet training complete  before 30 months  30-42 months  after 42 months
  - Did your child begin talking normally and then stop at some later date? If yes, explain: \_\_\_\_\_
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**Health & Medical Issues About Your Child**

Has your child experienced any of the following medical conditions?

- Yes  No Significant illness? If yes, explain: \_\_\_\_\_  
\_\_\_\_\_
- Yes  No Serious accident? If yes, explain: \_\_\_\_\_  
\_\_\_\_\_
- Yes  No Surgery/Hospitalization? If yes, explain: \_\_\_\_\_  
\_\_\_\_\_
- Yes  No Seizure? If yes, explain: \_\_\_\_\_  
\_\_\_\_\_

**Health & Medical Issues About Your Child (continued)**

- Yes  No    Fevers above 103 degrees?    If yes, explain: \_\_\_\_\_  
\_\_\_\_\_
  
- Yes  No    Vision problems?    If yes, explain: \_\_\_\_\_  
\_\_\_\_\_
  
- Yes  No    Wears glasses?    If yes, explain: \_\_\_\_\_
  
- Yes  No    Wears contacts?    If yes, explain: \_\_\_\_\_
  
- Yes  No    Hearing problems?    If yes, explain: \_\_\_\_\_
  
- Yes  No    Wears hearing aids?    If yes, explain: \_\_\_\_\_
  
- Yes  No    Repeated ear infections?    If yes, explain: \_\_\_\_\_
  
- Yes  No    Ever had tubes in ears?    If yes, explain: \_\_\_\_\_
  
- Yes  No    Significant head injury, concussion or loss of consciousness?    If yes, explain: \_\_\_\_\_  
\_\_\_\_\_
  
- Yes  No    Difficulty eating or drinking?    If yes, explain: \_\_\_\_\_  
\_\_\_\_\_
  
- Yes  No    Allergies?    If yes, explain: \_\_\_\_\_
  
- Yes  No    Has your child ever been diagnosed with ADD/Attention Deficit/Hyperactivity Disorder?  
If yes, explain: \_\_\_\_\_
  
- Yes  No    Does your child take medication?    If yes, explain: \_\_\_\_\_  
\_\_\_\_\_
  
- Yes  No    Has your child ever been treated for other medical/psychiatric disorders?    If yes, explain: \_\_\_\_\_  
\_\_\_\_\_

## Agency Involvement

Yes  No Does your child receive Department of Developmental Disability (DDD) services? If yes, what services: \_\_\_\_\_  
\_\_\_\_\_

Name/Telephone number of DDD Case Manager: \_\_\_\_\_

Yes  No Does your child receive any other outside services (e.g., *counselor, psychiatrist, neurologist*)? If yes, please provide the name of agency/doctor/type of services:  
\_\_\_\_\_  
\_\_\_\_\_

## Social Information

Please check those items which describe your child:

- |   |   |
|---|---|
| <input type="checkbox"/> participates in family activities        | <input type="checkbox"/> gets along well with others                                    |
| <input type="checkbox"/> is affectionate                          | <input type="checkbox"/> participates in outside activities (clubs, performing arts...) |
| <input type="checkbox"/> has a good self-image                    | <input type="checkbox"/> gets along with brothers and sisters                           |
| <input type="checkbox"/> has a close relationship with the mother | <input type="checkbox"/> has a close relationship with the father                       |
| <input type="checkbox"/> plays a musical instrument               | <input type="checkbox"/> has hobbies  |
| <input type="checkbox"/> has a positive attitude                  | <input type="checkbox"/> participates in social activities (scouts, church group, etc.) |

Please check those items which describe your child that **occur significantly more often** than would be expected for other children their age:

- |   |  |
|---|--|
| <input type="checkbox"/> has difficulties sleeping  | <input type="checkbox"/> has mood swings               |
| <input type="checkbox"/> has a short attention span | <input type="checkbox"/> has a poor memory             |
| <input type="checkbox"/> lies                       | <input type="checkbox"/> steals                        |
| <input type="checkbox"/> frustrates easily          | <input type="checkbox"/> acts without thinking         |
| <input type="checkbox"/> has temper tantrums        | <input type="checkbox"/> becomes angry often           |
| <input type="checkbox"/> is aggressive              | <input type="checkbox"/> experiences excessive sadness |
| <input type="checkbox"/> is withdrawn               | <input type="checkbox"/> has made suicide threats      |

Please indicate the following about your child:

General disposition/temperament:      easy-going      slow to warm up      difficult

General activity level:      low      average      high

Response when angry:      withdraws      cries      screams      hits

Please indicate how well your child gets along with:

Peers	Well	Okay	Poorly
Mother	Well	Okay	Poorly
Father	Well	Okay	Poorly
(Step Mother)	Well	Okay	Poorly
(Step Father)	Well	Okay	Poorly
Brother(s)	Well	Okay	Poorly
Sister(s)	Well	Okay	Poorly

What are your child's strengths? \_\_\_\_\_

\_\_\_\_\_

What things are difficult for your child? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What are your child's interests? What does your child like to do? \_\_\_\_\_

\_\_\_\_\_

Have there been any major life events that may have impacted your child recently (e.g., moved, divorce of parents, loss of a family member, etc.)? \_\_\_\_\_

\_\_\_\_\_

Is there any other information or concerns about your child that you would like to share?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Form completed by:

Date: