PARENT INPUT

Medical and Developmental Information and History
-CONFIDENTIAL-

Student Data:

Student Last Name:_____ **Student First Name**:_____
Date of Birth: _____

Family Information

With whom does the child live (Specify: Biological parents, adoptive parents, etc.). : _____
_____
LegalGuardian:_____
Natural Father: _____
Father's Occupation: _____
Cell #: _____ Email: _____
Health Problems Father:_____
Level of Education: (circle highest level attained)
(8th gr. / HS / some college or trade school / college / graduate school)
Natural Mother:_____
Mother's Occupation: _____
Cell #: _____ Email: _____

Health Problems-Mother: _____
Level of Education: (circle highest level attained)
(8th gr. / HS / some college or trade school / college / graduate school)
How many children in family household? _____
Ages of children: _____ _____ _____
_____ _____ _____

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:

_____ loss of their home
_____ parental separation/divorce
_____ incarceration of a family member
_____ death of a family member
_____ loss of employment of a major wage earner
_____ serious illness of a family member
_____ emotional problems/psychiatric history

If yes, explain:

_____
_____
_____
_____
_____

Educational Information

What is your understanding as to why your child is being referred for a possible evaluation? (if a re-evaluation, please leave blank):

_____

_____

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

_____

_____

Any other information or concerns you want to share with your child's school team?

_____

_____

_____

Has your child ever received Special Education services or Early Childhood Intervention Programming? _____

_____

Medical/Developmental/Health Information

Prenatal/Infancy/Delivery Information

Mother's age at birth:_____
Did the mother visit doctor regularly during pregnancy? Yes _____ No _____
Was there any difficulty during the pregnancy? Yes _____ No _____
If yes, please explain: _____

_____

_____

_____

_____

Did the mother take medication during pregnancy? Yes _____ No_____
If yes, please list: _____

Did the mother receive anesthesia during delivery? Yes _____ No_____
If yes, please list: _____

Did mother smoke during the pregnancy? Yes _____ No _____
Did mother use alcohol during pregnancy? Yes _____ No _____
Did mother use drugs during pregnancy? Yes _____ No _____
If yes, please list _____
Length of pregnancy: _____ weeks / _____ months
Any difficulty during delivery? Yes ___ No ___ Explain: _____

_____

Length of labor: _____ hour Birth: (circle one) Vaginal Cesarean

Any Complications? (cyanosis, meconium, cord compression, etc.) Yes __ No __ Explain: _____

_____

_____

Trauma to infant (lack of oxygen, life support, heart problems, etc.)? Yes __ No ___ Explain: _____

_____

Any birth defects? Yes __ No ___ Explain: _____

_____

Was there jaundice? Yes __ No ___ Explain and indicate treatment received : _____

_____

Was child released from hospital with mother? Yes ___ No __ Explain: _____

_____

Birth weight: _____lbs. _____oz.

Any difficulties during infancy? Yes ___ No ___ Explain: _____

_____

Were there any episodes of seizures? Yes ___ No __ Explain: _____

_____

Was there Anoxia (lack of oxygen)? Yes ___ No ___ Explain: _____

_____

Was there any use of life support systems? Yes ___ No ___ Explain: _____

_____

Did the child gain weight consistently during the first year of life? Yes ___ No ___ Explain: _____

_____

Developmental History

__Parent reports developmental milestones were within normal parameters.

-OR-

__Parent indicated the following areas of developmental delays:

When did your child begin the following?

Rolling over by self:	Before 2 mos.	3-4 mos.	After 6 mos.
Sitting without support:	Before 5 mos.	5-8 mos.	After 8 mos.
Crawling on hands and knees:	Before 6 mos.	6-9 mos.	After 9 mos.
Walking independently:	Before 10 mos.	10-18 mos.	After 18 mos.
Saying first words:	Before 12 mos.	12-18 mos.	After 18 mos.
Talking in simple 2-3 word sentences	Before 24 mos.	24-36 mos.	After 36 mos.
Toilet training begun:	Before 24 mos.	24-40 mos.	After 40 mos.
Toilet training complete:	Before 30 mos.	30-42 mos.	After 42 mos.

Did your child begin talking normally, then stop at some later date? Yes _____ No _____

If yes, please explain: _____

_____

_____

Medical History

__According to the health history, student has had no serious illnesses or injuries.
-OR-
__According to the health history, student has experienced the following difficulties:

Significant illness? **Y N** Explain: _____

Serious accident? **Y N** Explain:_____

Surgery/Hospitalization? **Y N** Explain: _____

Seizures? **Y N** Explain: _____

Fevers above 103 degrees? **Y N** Explain_____

Vision problems? Yes __ No ___ Glasses or Contacts?
Explain:_____

Hearing problems? Yes ___ No ___
Wears hearing aids? Yes ___ No ___ Explain: _____
Repeated ear infections/tubes? Yes __ No __ Explain: _____
Asthma? Yes __ No _____

Significant head injury, concussion, loss of consciousness? Yes ___ No ___ Explain: _____

_____
Difficulty eating or drinking? Yes ___ No __ Explain: _____
Takes medication (Please list): _____

Respiratory Problems? Yes __ No _____

Has your child ever been diagnosed with ADD/Attention Deficit/Hyperactivity Disorder? Yes _____ No _____
Explain: _____

Has your child ever been treated for other medical/Psychiatric disorders? Yes _____ No _____
When? _____

Functional Information

Please check the following that describe your child:

____overactive
____socially avoidant
____easily frustrated
____ often unhappy
____ fire-setting
____ self-mutilating
_____ peer difficulties
_____ short attention span
_____ aggressive
_____ homework problems
_____ impulsive
_____ truant

____ shy
____ cruel to animals
____ lacks self control
____ unmotivated
____ drugs/alcohol
____ overreacts when faced with a challenge

_____ under active
_____ disruptive
_____ over anxious
_____ excessive fears
_____ defiant
_____ disorganized

Is there any other information about your child that you would like to share? (household composition, family finances, parent work history, housing history, child's ordinal position, intrafamilial relationships, contact with extended family, important changes in family in relation to current problem, contact with other agencies, parent's description of behavior at home including play habits, responsibilities, personality traits, discipline used, relationships with peers, siblings, parents)

_____

_____

_____

IF YOUR CHILD IS IN PRESCHOOL, Please answer these additional questions.

Does the child have problems with any of the following? (Check all that apply)
Chewing __ swallowing ___ drooling ___

Does your child respond to: (Check all that apply)
touch ___ noise___ voices___ speech___

In what ways does your child respond? Check all that apply:
moves body ___ moves head ___ gestures ___ signs __ makes sounds ___ uses speech ___

Your child's speech is best described as follows (Check one):
Has no speech___
Speech is not understandable at all___
Speech is usually understood by family members but rarely by strangers___
Speech is normal for a child of this age___

The number of words your child uses is:
Less than 10___ 10-50___ 50-100___ more than 100___

Your child says:
Single words ___ 2 to 3 words together___ 3 to 4 words together___ speaks in sentences___

What is the most independent thing your child can do?_____

Does your child need any special equipment to be as independent as possible?_____