Dear _____

We would appreciate your assistance in collecting information about your child as we begin the evaluation process. Feel free to add any additional information or comments that you feel are important. **Please _return this form_ AND _the signed Consent for Evaluation form_ to** _____.

Child's Social Security Number _____

Child's Last Name _____   Child's First Name _____

Birth Date _____   M/F _____   School District _____

Parent/Guardian Name _____   Home Phone _____

Address _____   City/Zip _____

Child is presently living with:

☐ Biological Mother   ☐ Stepmother   ☐ Adoptive Mother   ☐ Foster Mother

☐ Biological Father   ☐ Stepfather   ☐ Adoptive Father   ☐ Foster Father

Other (Specify): _____   Language Spoken in the Home: _____

Best time(s) to contact parent/guardian by phone: _____

FAMILY

Mother's Name: _____

Occupation: _____   Work Telephone Number: _____

School: Highest grade completed _____

Special Assistance in School? (ex.: tutoring, etc.) _____

Medical/Emotional Concerns: _____

Father's Name: _____

Occupation: _____   Work Telephone Number: _____

School: Highest grade completed _____

Special Assistance in School? (ex.: tutoring, etc.) _____

Medical/Emotional Concerns: _____

LIST STUDENT'S BROTHERS AND/OR SISTERS

	Name	Age	Medical/Social/School Concerns
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

PREGNANCY/BIRTH MEDICAL HISTORY

Birth Weight: _____   Did the pregnancy go to full term? ☐ **Yes**   ☐ **No**

If yes, please describe: _____

If no, how many weeks early? _____

Were there any complications with this pregnancy? (e.g., infection, toxemia, hospitalization) ☐ **Yes**   ☐ **No**

If yes, please describe: _____

_____

_____

Were there any difficulties during/after the delivery? _____

_____

_____

CHILD'S MEDICAL HISTORY

If your child's medical history includes any of the following, please write down the date when the incident or illness occurred and any other important information:

Childhood diseases (describe ages and any complication): _____

_____

Operations: _____

Hospitalization for illness: _____

Head/Major injuries: _____Coma: _____

Respiratory and/or Cardiac Difficulties: _____Frequent colds: _____

Convulsions, seizures, epilepsy: _____Cytomegalovisrus (CMV): _____

Persistent high fever: _____

Tics: (i.e., eye blinking, sniffing, any repetitive, non purposeful movements) _____

Ear Problems: (i.e., ear infections) _____Tubes in ear(s):_____

Allergies or Asthma: _____

Any concerns about your child's vision? _____Any concerns about your child's hearing?_____

Other: _____

PRESENT MEDICAL CONDITIONS OF THE CHILD BEING REFERRED

Present illnesses for which the child is being treated: _____

Medications child is taking on a regular schedule:_____

Child's Doctor: _____

Address: _____Phone: _____

EARLY DEVELOPMENT (birth to age 5)

Activity level – Describe your child's **PHYSICAL ACTIVITY LEVEL.** ☐ high ☐ average ☐ low

Explain: _____

Distractibility – Describe your child's **ABILITY TO STAY ON TASK.** ☐ high ☐ average ☐ low

Explain: _____

Adaptability – Describe how your child deals with **SUDDEN CHANGES.** ☐ good ☐ average ☐ poor

Explain: _____

Approach/Withdrawal – Describe your child's response to **NEW SITUATIONS.** ☐ good ☐ average ☐ poor

EARLY INTERVENTION OR PRESCHOOL HISTORY

Describe briefly any developmental/preschool concerns you are aware of:_____

What has been attempted? Successful? _____

Past residences (please list School Districts)	Special Services received
_____	_____
_____	_____

Do you have any additional concerns you would like addressed during the evaluation process? Please describe. _____

_____

_____

If you have any questions or need assistance in completing this form, please call

_____ **at** _____

Thank you for your assistance.

_____   _____

District/Cooperative Staff   Date