Parent Input / Contact Form
Screening Information

Name of Student: _____ Date: _____
Student ID: _____ Date of Birth: _____

Dear Parent / Legal Guardian,

Your input is needed in order to complete the screening process. Please complete the following information and return it to school as soon as possible. Also, please provide copies of any reports or evaluation from other sources that may be relevant to the review.

Address: _____ City, State, Zip: _____

E-Mail Address: _____ Phone: _____ Cell Phone: _____

Family Information (name)		Employment	check if living with child
Mother	_____	_____	☐
Stepmother	_____	_____	☐
Father	_____	_____	☐
Stepfather	_____	_____	☐

Is student living with legal guardian? ☐ Yes ☐ No
If no, please provide contact information for the student's legal guardian:

Name: _____
Address: _____ City, State, Zip: _____

E-Mail Address: _____ Phone: _____ Cell Phone: _____

Siblings (name)		Age	check if living with child
Brother(s)	_____	_____	☐
	_____	_____	☐
Sister(s)	_____	_____	☐
	_____	_____	☐

Primary Language Spoken in the Home: _____
Secondary Language Spoken in the Home: _____

Background / Developmental History:

☐ Yes ☐ No Pregnancy or birth complications?
normal delivery
complications: List: _____

☐ Yes ☐ No Developmental milestones were attained within normal limits. Examples include:
feeding problems, sleep problem, developmental milestone problems, sit, crawl, walk, talk, toilet training

_____
_____
_____

How would you describe your child's level of activity? ☐ Overactive ☐ Average ☐ Underactive

School History (list all schools where your child has received his/her education)

LIST NAME OF SCHOOL AND GRADES ATTENDED

	SCHOOL NAME	GRADE
1	_____	_____
2	_____	_____
3	_____	_____
4	_____	_____
5	_____	_____

Has your child ever repeated a grade? ☐ yes ☐ no When/Why?

_____

_____

Strengths: Understandably the intent of this questionnaire is to understand the nature and extent of problem areas your child may be having. But please take a moment to focus on what you think your child's strengths may be. What constructive things does your child like to do?

_____

_____

_____

What academic, emotional, behavioral, or social problems has your child had in school? *(Include special education, learning difficulties, disruptions, attention problems, authority difficulties, underachieving, altercations, incidents of truancy, problems requiring school discipline, suspensions, expulsions, etc).* Please include SCHOOL, YEAR, PROBLEM and any CONSEQUENCES.

_____

_____

_____

_____

Area	None	Specific Concerns
Vision	☐	☐ **Student wears glasses** Other Concerns: _____
Hearing	☐	Concerns:
Health	☐	Are there any medical concerns or diagnoses that we need to be made aware? Please list and note any medication: _____ Other Concerns: _____
Fine Motor	☐	**Student has been seen for outside occupational therapy** Place: _____ Students Age: _____ Length of Services: _____ Other Concerns: _____

Area	None	Specific Concerns
Gross Motor	☐	**Student has been seen for outside physical therapy** Place:_____ Students Age Services Started:_____ Length of Services:_____ Other Concerns:_____
Communication: Speech	☐	**Student has been seen for outside speech therapy** Place:_____ Students Age:_____ Length of Services:_____ Other Concerns:_____
Communication: Language	☐	Receptive (listening and understanding what is communicated):_____ Expressive (speaking):_____ Other Concerns:_____
Cognitive	☐	Remembers Facts/Retention of information: Learning:_____ Cognitive/Intellectual:_____ Other Concerns:_____
Adaptive	☐	Dressing:_____ Eating:_____ Grooming:_____ Toileting:_____ Other:
Academic	☐	☐ Student has been seen for outside tutoring service Place:_____ Students Age:_____ Length of Services:_____ How would you rate your child's academic learning? ☐ Below Average ☐ Average ☐ Above Average Other Concerns:_____
Transition *(16 years and older)*	☐	
Social/Emotional and Behavioral	☐	☐ Student has been seen for counseling Place:_____ Students Age:_____ Length of Services:_____ Has your child ever been assessed or evaluated for emotional, psychological, educational, or behavioral concerns? ☐ yes ☐ no Please list:_____ Other Concerns:_____ ☐ normal social interaction ☐ isolates self ☐ very shy ☐ few friends ☐ difficulty making friends ☐ difficulty keeping friends

Forms Completed By: _____

Signature: _____ **Date:** _____