3rd-8th GRADE PARENT OBSERVATION FORM
(Please Print)

Name of Child:_____Birthdate:_____

Parent(s)
Name:_____

Occupation: Father:_____

Mother:_____

Child's Family Includes:

Brothers (Names and Ages)_____

Sisters (Names and Ages)_____

Please answer the questions in the best manner possible. Your answers will assist the school in providing the best support for your child. The information is confidential and your responses will only be shared with school personnel responsible for planning the educational program best for your child.

General Health History

Please circle any health concerns about your child that you or your doctor has observed:

Asthma	Bedwetting	Loss of consciousness
Indigestion	Allergies	Diabetes
Constipation	Serious blow to head	Overtired or lacking pep
Diarrhea	Headaches	Heart trouble
Vomiting	Nightmares	Hyperactivity
Stomach aches	Medical problems after birth	Frequent fevers
Nail biting	Substance abuse victim	Nose bleeding
Sinus trouble	Seizures (Epilepsy)	

Chronic ear infections (more than 2x per year)

Other Physical issues (please explain):

_____
_____
_____

Is your child currently on medications? (if so, please explain what)

_____
_____

Has your child had any significant injuries or hospitalizations? (if so, please explain)

_____
_____

Has your child had an ear/hearing examination or treatment? Yes____ No_____

When:_____ Results:_____

At what age did your child first begin to speak? (approximate)_____

Does your child stutter or have difficulty expressing ideas or concepts?_____

Has your child ever had a vision examination requiring treatment? Yes_____ No_____

When:_____Results:_____

Please check to indicate your observation of the following:

					Comments
SENSE OF RESPONSIBILITY	☐very responsible	☐usually responsible	☐sometimes responsible	☐rarely responsible	
CONSIDERATION OF OTHERS	☐very considerate	☐usually considerate	☐sometimes considerate	☐rarely considerate	
PEER RELATIONSHIPS	☐enjoys good relationships	☐satisfactory relationships	☐has occasional issues	☐relates poorly	
LEADERSHIP SKILLS	☐excellent	☐good	☐average	☐poor	
EMOTIONAL MATURITY	☐very mature	☐average maturity	☐somewhat immature	☐very immature	
SELF-CONFIDENCE	☐healthy self-image	☐needs some support	☐seems overly confident	☐poor self-image	

SELF-CONTROL	☐good self-control	☐usually good self-control	☐misbehaves occasionally	☐frequently disruptive	
RELATIONSHIP WITH ADULTS	☐very comfortable	☐is uneasy	☐is dependent	☐is uncooperative	

☐

Additional comments:_____

_____

_____

What hobbies/interests does your child have in and out of school?

_____

_____

_____

Has your child ever been recommended for or identified as needing:

- Psycho-Educational testing Yes_____No_____
- IEP/504 plan Yes_____No_____
- Special education Yes_____No_____
- Gifted program Yes_____No_____
- Grade retention Yes_____No_____
- Reading remediation Yes_____No_____
- Math remediation Yes_____No_____
- Writing remediation Yes_____No_____
- Counseling Yes_____No_____
- Occupational therapy Yes_____No_____
- Physical therapy Yes_____No_____
- Speech therapy Yes_____No_____
- Behavioral therapy Yes_____No_____
- English as second language Services Yes_____No_____

If you checked yes to any of the above, please include necessary documents (i.e. Educational psychological, IEP/504, any evaluations, comments) which would be helpful in supporting your child.

_____

_____

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