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**Office Use Only**

P- \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SS - \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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 twice 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 | ࿘usuallyresponsible | ࿘sometimesresponsible | ࿘rarelyresponsible |  |
| CONSIDERATIONOF OTHERS | ࿘very considerate | ࿘usuallyconsiderate | ࿘sometimesconsiderate | ࿘rarelyconsiderate |  |
| PEERRELATIONSHIPS | ࿘enjoys goodrelationships | ࿘satisfactoryrelationships | ࿘has occasionalissues | ࿘relatespoorly |  |
| LEADERSHIPSKILLS | ࿘excellent | ࿘good | ࿘average | ࿘poor |  |
| EMOTIONALMATURITY | ࿘very mature | ࿘average maturity | ࿘somewhatimmature | ࿘very immature |  |
| SELF-CONFIDENCE | ࿘healthy self-image | ࿘needs somesupport | ࿘seems overlyconfident | ࿘poor self-image |  |
| SELF-CONTROL | ࿘good self-control | ࿘usuallygood self-control | ࿘misbehavesoccasionally | ࿘frequentlydisruptive |  |
| RELATIONSHIPWITH ADULTS | ࿘very comfortable | ࿘is uneasy | ࿘is dependent | ࿘is uncooperative |  |

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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 Yes\_\_\_\_\_No\_\_\_\_\_

 Services

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.