K4-2ND 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	Thumb sucking	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 of 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 or treatment? Yes_____ No_____

When:_____Results:_____

At what age did your child begin walking? (approximate)_____

Do you feel your child has adequate large muscle coordination?_____

Does your child:	Yes	No
Have regular playmates the same age?		
Have difficulty getting along with other children?		
Prefer to play with other children instead of alone?		
Become easily frustrated?		
Cry often?		
Lose temper easily?		
Enjoy cooperating with others?		

Become frequently moody or irritated?		
Become upset by changes in routine?		
Have difficulty dealing with stress such as illness, death, or separation?		
Demand much individual adult attention?		
Accept discipline and limits?		

Additional comments:_____
_____
_____

Has your child attended a preschool or daycare? Yes____ # of years_____ No____

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_____