# AVON VILLAGE ELEMENTARY

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## EARLY PREVENTION OF SCHOOL FAILURE
## PARENT OBSERVATION FORM

**Today's Date** ______________________

**Name of Child:** ________________________________ **Date of Birth:** ____________________

**Parent's Name:** ____________________________________________

Number  Street  Apt#  City  State  Zip

**Address:** ____________________________________________

**Daytime Telephone No:** ____________________________________________

**Father's Occupation:** ______________________ **Mother's Occupation:** ______________________

| **Siblings:** | **Names of Brothers** | **Age** | **Names of Sisters** | **Age** |
|---|---|---|---|---|
| | ____________ | ____ | ____________ | ____ |
| | ____________ | ____ | ____________ | ____ |
| | ____________ | ____ | ____________ | ____ |
| | ____________ | ____ | ____________ | ____ |

Please answer the questions on this form in the best way that you can. You will be able to answer some quite easily and you may have difficulty in making a decision on others.

Your answers on this form will help the school staff. The teacher, along with your input, will help decide the educational program which is best suited for your child.

This questionnaire is confidential and your responses will be shared only with the professional personnel and only if the information learned will help in planning an educational program for your child.

**I. General Health History**

Please check any health concern that you or your doctor observed:

| | | | | | |
|---|---|---|---|---|---|
| ____ | Asthma | ____ | Bed wetting | ____ | Loss of consciousness |
| ____ | Indigestion | ____ | Allergies | ____ | Chronic ear infections (more than 2 per year) |
| ____ | Constipation | ____ | Serious blows to head | | |
| ____ | Diarrhea | ____ | Headaches | ____ | Overtired or lacking pep |
| ____ | Vomiting | ____ | Nightmares | ____ | Heart trouble |
| ____ | Stomachaches | ____ | Thumb sucking | ____ | Hyperactivity |
| ____ | Frequent fevers | ____ | Nail biting | ____ | Medical problems immediately after birth |
| ____ | Sinus troubles | ____ | Epilepsy (seizures) | ____ | Substance abuse victim |
| ____ | Nose bleeding | ____ | Diabetes | ____ | Fainting |

____ Other physical problems (explain): ______________________________

Is this child presently on medication? __________ What? ______________________

Has child had any significant injuries or hospitalization? ______________________

Is child "healthy" on day of assessment? ______________________

## II. Hearing Assessment

Has the child ever had any ear/hearing examination or treatment? ______ Yes ______ No

When? ______________ By Whom? ______________________________

Results ______________________________________________

______________________________________________

A. Do you suspect any hearing problems? ______ Yes ______ No

B. Does your child:

1. Seem to have difficulty hearing? ______ Yes ______ No
2. Turn up the TV louder than other members of the family? ______ Yes ______ No
3. Seem to favor one ear over the other? ______ Yes ______ No
4. Jump or appear to be more startled than others if there is a sudden noise? ______ Yes ______ No
5. Seem to hear you if you talk in a whisper? ______ Yes ______ No
6. Make you talk loudly or repeat frequently? ______ Yes ______ No
7. Become confused in following more than two verbal directions at a time? ______ Yes ______ No
8. Have difficulty remembering things for a long time? ______ Yes ______ No
9. Have difficulty remembering things for a short time? ______ Yes ______ No

## III. Language Development

At what age did your child first begin to speak? Give approximate age if you do not remember exact age:

First words ______________

Two or three words together ______________

Sentences ______________

Does your child:

1. Stutter ______ Yes ______ No
2. Have difficulty expressing ideas and concepts? ______ Yes ______ No

## IV. Visual Assessment

Has the child ever had any vision examination or treatment? ______ Yes ______ No

When? ______ By Whom? ______________________________

Results ______________________________________________

______________________________________________

A. Do you suspect any vision problems? ______ Yes ______ No

B. Does your child:

1. Seem to have difficulty seeing small lines or pictures? ______ Yes ______ No
2. Seem to have a problem seeing things far away? ______ Yes ______ No
3. Squint? ______ Yes ______ No
4. Wear glasses? ______ Yes ______ No
5. Have eyes that turn in? ______ Yes ______ No
6. Have eyes that turn out? ______ Yes ______ No
7. Sit very close to television? ______ Yes ______ No
8. Rub eyes a lot? ______ Yes ______ No
9. Turn head as to use primarily one eye? ______ Yes ______ No

10 Lower one side of the head when looking at others? ______ ______

## V. Motor Development

This child began walking at what age? (if a guess, please label as such) Age ______________

A. Do you feel your child has adequate large muscle coordination? ______ Yes ______ No

B. Does your child:

1. Catch a ball thrown to him? ______ Yes ______ No
2. Enjoy physical activity? ______ Yes ______ No
3. Lose balance, trip and fall more often than "normal"? ______ Yes ______ No
4. Have difficulty running? ______ Yes ______ No

## VI. Social Development

Does your child:

1. Have regular playmates the same age? ______ Yes ______ No
2. Have difficulty getting along with other children? ______ Yes ______ No
3. Prefer to play with other children instead of alone? ______ Yes ______ No
4. Become easily frustrated? ______ Yes ______ No
5. Cry often? ______ Yes ______ No
6. Have a bad temper? ______ Yes ______ No
7. Enjoy cooperating with others? ______ Yes ______ No
8. Become frequently irritated or moody? ______ Yes ______ No
9. Become upset by changes in routine? ______ Yes ______ No
10. Have difficulty dealing with family stress such as illness, death, or separation? ______ Yes ______ No
11. Demand much individual adult attention? ______ Yes ______ No
12. Accept discipline and limits? ______ Yes ______ No

## VII. Other

Is there any other information that will help us understand this child?

Has the child attended a preschool? ______ Yes ______ No ______ No. of years

Does your child know how to read? ______ Yes ______ No

Does your child know how to write? ______ Yes ______ No

Would you like an individual conference with the school psychologist to relate any information you don't feel you can include on this form? ______ Yes ______ No