V. MOTOR DEVELOPMENT

Your child began walking at what age (please indicate if estimate) _____

Do you feel your child has adequate large muscle coordination? Y N

Does your child:

1. Catch a ball thrown to him/her? Y N
2. Enjoy physical activities? Y N
3. Lose balance, trip and fall more than normal? Y N
4. Have difficulty running? Y N

Is your child left- or right-handed? Left Right

VI. SOCIAL DEVELOPMENT

Does your child:

1. Have regular playmates the same age? Y N
2. Have difficulty getting along with other children? Y N
3. Prefer to play with other children instead of alone? Y N
4. Become easily frustrated? Y N
5. Cry often? Y N
6. Have a bad temper? Y N
7. Enjoy cooperating with others? Y N
8. Become frequently irritated or moody? Y N
9. Become upset by changes in routine? Y N
10. Demand much individualized adult attention? Y N
11. Accept discipline and limits? Y N
12. Have difficulty dealing with family stress such as illness, death or adoption? Y N
13. Does your child separate easily from you (such as when being dropped off at pre-school or a sitter) Y N
14. Does your child have any fears? Y N

If the answer to # 12, 13, or 14 is yes, please provide details.

_____

Has your child attended a preschool? Y N

Please indicate the name _____

Is there a history of learning disabilities within your family? Y N

If yes, please explain _____

VII. Is there any other information that will help us understand your child (i.e. strengths, weaknesses, habits, etc.)?

_____

Saint Peter's School
Early Prevention of School Failure
Parent Observation Form

Instructions: ***Please bring this form with you to Kindergarten screening.*** **Attach a recent photo of your child. Answer the questions on this form as completely and accurately as possible. For any answers that require additional information, please attach a separate sheet of paper or copies of any appropriate documentation. The information on this form is confidential and will be used by the school staff only to develop the best education program for your child.**

Name of Child _____ **Date of Birth** _____

Father's Name _____ **Resides w/child? Y N**

Mother's Name _____ **Resides w/child? Y N**

Child's Address _____

_____

Occupation – Father _____

Occupation – Mother _____

Please list child's siblings (include name, gender, age)

_____ M F

_____ M F

_____ M F

_____ M F

Please list any other extended family members that reside with child _____

Please provide Saint Peter's with copies of all Pre-school reports from your child's current or previous pre-schools.

I. LANGUAGE DEVELOPMENT

Has your child ever had any assessment for language and/or learning difficulty? **Y N**
If yes, please explain date, physician/tester and results.

_____

Do you suspect any language or learning problems? **Y N**

Is English the primary language spoken at home? **Y N**
If no, please indicate primary language spoken at home.

_____

At what age did your child first begin to speak?
(Give approximate age if necessary)

First words _____Two or three words_____ Sentences_____

Does your child:
1. Stutter? **Y N**
2. Have difficulty expressing ideas/concepts? **Y N**
3. Have difficulty understanding verbal information or verbal directions? **Y N**

II. General Health History – Please check any health concern that you or your doctor has noticed.

___Asthma ___Bed wetting ___Indigestion
___Constipation ___Diarrhea ___Vomiting
___Stomachaches ___Frequent fevers ___Sinus Trouble
___Nose Bleeds ___Allergies ___Headaches
___Nightmares ___Thumbsucking ___Nail Biting
___Seizures ___Diabetes ___Hyperactivity
___Heart Trouble ___Overtired/Lacking Pep
___Serious Blows to the Head ___Loss of consciousness
___Chronic Ear Infections (more than 2 per year)
___Medical Problems immediately after birth
___Other Physical Problems (explain) _____

Is child presently on medication? **Y N**
If yes, please explain_____

Please describe any hospitalizations or significant injuries (If necessary provide details on a separate sheet of paper)

_____

_____

II. HEARING ASSESSMENT

Has your child ever had any ear/hearing examination or treatment? **Y N**
If yes, please explain date, physician/tester and results.

_____

Do you suspect any hearing problems? **Y N**

Does your child:
1. Seem to have difficulty hearing? **Y N**
2. Turn up the TV louder than other members of the family? **Y N**
3. Seem to favor one ear over the other? **Y N**
4. Jump or appear to be more startled than others if there is a sudden noise? **Y N**
5. Seem to hear you if you talk in a whisper? **Y N**
6. Make you talk loudly or repeat frequently? **Y N**
7. Become confused in following more than two verbal directions at a time? **Y N**
8. Have difficulty remembering things for a long time? **Y N**
9. Have difficulty remembering things for a short time? **Y N**
10. Enjoy listening to stories and is he/she able to answer questions about what was read? **Y N**

IV. VISUAL ASSESSMENT

Has your child ever had a vision examination or treatment? **Y N**
If yes, please explain date, physician/tester and results

_____

Do you suspect any vision problems? **Y N**

Does your child:
1. Seem to have difficulty seeing small lines or pictures? **Y N**
2. Seem to have a problem seeing things far away? **Y N**
3. Squint? **Y N**
4. Wear glasses? **Y N**
5. Have eyes that turn in? **Y N**
6. Have eyes that turn out? **Y N**
7. Sit very close to the television? **Y N**
8. Rub eyes a lot? **Y N**
9. Turn head as to use primarily one eye? **Y N**
10. Lower one side of the head when looking at others? **Y N**