PARENT/CAREGIVER INPUT FORM

Student's name ___________________ Age ________ School ___________________ Date of Birth _____________
Person Completing Report ____ Today's Date ____________________
Relationship to Student ___________________ Social Security Number _______________ Phone # ____________
Mailing Address ____
Physical Address ____

PLEASE COMPLETE ALL ITEMS YOU FEEL COMFORTABLE COMPLETING. IF YOU NEED ASSISTANCE OT HAVE QUESTIONS CALL THE OFFICE OF SPECIAL PROGRAMS AT 304.256.4555 AND TELL THE SECRETARY THE SCHOOL YOUR CHILD ATTENDS. SOMEONE WILL PUT YOU IN CONTACT WITH THE SCHOOL'S CASE MANAGER. THANK YOU

PRESENT PROBLEM

Explain the current concerns for your child: ____
____
____
When did your concerns begin? ____
What services and/or help does your child receive to address concerns?
___special education ___counseling ___behavior support ___extra instruction ___medication
Describe noticed changes in your child's academic performance ____
Describe noticed changes in your child's behavior ____
____
Has your child received evaluation or treatment for the current problem or similar problems? (If yes, explain)
____
What strategies/supports appears to work? ____
What strategies/supports DON'T work? ____
What motivates your child?____
Rate how your child gets along with others in school (1=Poor – 5=great) 1 2 3 4 5
Rate how your child gets along with others in the community (1=Poor – 5=great) 1 2 3 4 5
What teacher(s)/staff work best with your child? ____
With what teacher(s)/staff does your child have trouble? ____
Have you ever been to school over these concerns?____ If yes, what was the outcome? ____________________
____

FAMILY INFORMATION

Lives with: (Check One) Biological Parent___ Family member ___ Adopted Parent ___ Foster Parent ___
Agency Involved (If applicable) ______________________________Age of placement ______________________
Mother's Name/ Occupation____Age________
Father's Name/ Occupation____Age________
Circle years of education completed:
Mother K 1 2 3 4 5 6 7 8 9 10 11 12 College graduate - Other
Father K 1 2 3 4 5 6 7 8 9 10 11 12 College graduate - Other

List all individuals living in the home:

NAME	AGE	HEALTH STATUS	RELATIONSHIP TO CHILD
____________________________	_______	______________________	_________________________
____________________________	_______	______________________	_________________________
____________________________	_______	______________________	_________________________
____________________________	_______	______________________	_________________________
____________________________	_______	______________________	_________________________
____________________________	_______	______________________	_________________________

Have there been any of the following changes/stressors in the family? Please check and explain.

____ A move in the last 3 years. (How many?)____

____ Divorce or separation of parents in the last 3 years.____

____ Death or serious illness of important family member in the last 3 years.____________________________

____ Current unemployment or monetary stress.____

____ Unusual working hours.____

____ New step-parent or change in family structure in the last 3 years._________________________________

Is there a family history of the following? Please check all that apply:

___ Mental Impairment
___ Developmental delays
___ Vision problems
___ Anxiety disorder
___ Depression
___ Drug use/abuse
___ Learning disability
___ Speech/language problems
___ Hearing problems
___ Bipolar disorder
___ Schizophrenia
___ Trauma
___ Autism/Aspergers
___ Seizures or epilepsy
___ Attention deficit hyperactivity disorder
___ Physical/mental abuse
___ Other physical or mental health family history: ____

STUDENT HEALTH HISTORY

Does your child have any diagnoses? Yes ____ No ____ If yes, please list: ________________________________
____
What medication are prescribed and by whom? ____
Counseling, if so by whom? ____
Has your child been evaluated by an outside agency? If so, list: ____
____
Are any other agencies involved with your child? If so, list by name ______________________________________
How long does your child usually sleep at night _____ Typical bedtime ____________Does s/he have problems falling asleep? _____ Does s/he awake at night on a regular basis? _____ If so, usually how many times ______

Please indicate the following current or past chronic health problems your child has exhibited.

___ Ear infections
___Breathing problems
___ Diabetes
___Frequent headaches
___ Memory problems
___ High fevers
___ Heart problems
___Convulsions/seizures
___ Vision problems
___ Extreme tiredness
___ Hearing problems
___Lead poisoning
___ Loss of consciousness

Has your child had any of the following? (If yes, please explain)

___ Head injury ____
___ Accidents ____
___ Poisoning ____
___ Surgery/hospitalization ____
___ Allergies ____
___ Asthma ____

STUDENT'S BIRTH HISTORY

Age of Mother at birth _________ Age of Father at birth _________
Health of Mother during gestation ____
Amount of alcohol used by Mother ____
Drugs and medications used by Mother ____
Cigarettes: How much/often ____
Premature _____________ On time ______________ Late _____________
Head first _____________ Cesarean ______________ Reason _____________
Birth weight _____________ Other ______________
Complications to baby ____
____
Did the baby need oxygen or resuscitation? ____
Was you child late meeting any developmental milestones (e.g., sitting, crawling, walking, talking, etc.)
_____ If so, which milestone(s) was s/he late to develop? ______________________________________
____

STUDENT'S SCHOOL HISTORY

Has your child been retained? _________ If so, what grade? __________
Has your child been suspended or expelled? ____ If so, explain ______________________________________
____
Have teachers complained about behavior problems? ____ If so, please explain __________________________
____
Does your child miss much school? ____ If so, please explain ____
Previous schools attended ____
What skills do you want your child to develop to be more independent? _________________________________
____

STUDENT'S BEHAVIOR

What observable events allow you to predict misbehavior (task, time, peers, requests, etc.)?________________
____
When/where is your child successful during the school day? ____
When your child misbehaves, what happens?____
What type of discipline works for you? ____
Has your child ever been in trouble with the law?____
What concerns do you have about your child's behavior? ____
____

Does you child have difficulty with the following?

	YES	NO		YES	NO
Temper tantrums	___	___	Nightmares	___	___
Thumb sucking	___	___	Aggression	___	___
Impulsivity	___	___	Overactive	___	___
Stubborn	___	___	Fearful	___	___
Takes risks	___	___	Clumsy	___	___
Rocks	___	___	Bangs head	___	___
Bites nails	___	___	Uses alcohol	___	___
Uses drugs	___	___	Odd habits	___	___
Smokes	___	___	Pulls hair	___	___

COMMENTS: ____
____
____
____
____
____

____

Signature of Person Completing Report **Date Completed**