

Saint Luke Catholic School
7005 Georgetown Pike
McLean, Virginia 22101

PARENT OBSERVATION FORM
(Please print all information)

Name of Child _____ Birthdate _____

Parent's Name _____

Address _____

Daytime Telephone No (_____) _____ Evening (_____) _____

Occupation: Father _____

Mother _____

Child's Family Includes:

Brothers (Names and Ages)

Sisters (Names and Ages)

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 assist the school in deciding what kind of educational program is best suited for your child.

This questionnaire is confidential and your responses will be shared only with 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 concerns that you or your doctor observed:

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

Other physical problems (please 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 this child ever had any ear/hearing examination or treatment? (Mark one) Yes No

When? _____ By Whom? _____

Results: _____

	Yes	No
A. Do you suspect any hearing problems?	<input type="checkbox"/>	<input type="checkbox"/>
B. Does your child:		
1. Seem to have difficulty hearing?	<input type="checkbox"/>	<input type="checkbox"/>
2. Turn up the TV louder than other members of the family?	<input type="checkbox"/>	<input type="checkbox"/>
3. Seem to favor one ear over the other?	<input type="checkbox"/>	<input type="checkbox"/>
4. Jump or appear to be more startled than others if there is a sudden noise?	<input type="checkbox"/>	<input type="checkbox"/>
5. Seem to hear you if you talk in a whisper?	<input type="checkbox"/>	<input type="checkbox"/>
6. Make you talk loudly or repeat frequently?	<input type="checkbox"/>	<input type="checkbox"/>
7. Become confused in following more than two verbal directions at a time?	<input type="checkbox"/>	<input type="checkbox"/>
8. Have difficulty remembering things for a long time?	<input type="checkbox"/>	<input type="checkbox"/>
9. Have difficulty remembering things for a short time?	<input type="checkbox"/>	<input type="checkbox"/>

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:

Stutter? _____ Yes _____ No
Have difficulty expressing ideas and concepts? _____ Yes _____ No

IV. VISUAL ASSESSMENT

Has your child ever had a vision examination or treatment? _____ Yes _____ No

When? _____ By Whom? _____
Results _____

	Yes	No
A. Do you suspect any vision problems?	_____	_____
B. Does your child:		
1. Seem to have difficulty seeing small lines or pictures?	_____	_____
2. Seem to have a problem seeing things far away?	_____	_____
3. Squint?	_____	_____
4. Wear glasses?	_____	_____
5. Have eyes that turn in?	_____	_____
6. Have eyes that turn out?	_____	_____
7. Sit very close to television?	_____	_____
8. Rub eyes a lot?	_____	_____
9. Turn head as to use primarily one eye?	_____	_____
10. Lower one side of the head when looking at other?	_____	_____

V. MOTOR DEVELOPMENT

This child began walking at age (if guess, label as such) Age _____

Do you feel your child has adequate large muscle coordination? _____ Yes _____ No

Does your child:

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

VI. SOCIAL DEVELOPMENT

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

VII. OTHER INFORMATION

Is there any other information that will help us to better understand your child? _____

	Yes	No	# of years
Has your child attended a preschool?	_____	_____	_____
Does your child know how to read?	_____	_____	
Does your child know how to write?	_____	_____	