



Our Lady of the Angels School

Kindergarten Parent Observation Form

Name of Child _____ Birthdate _____

Parent's Name _____

Address _____

Daytime Telephone No. _____

Occupation (Father's) _____

(Mother's) _____

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 help the school staff and will involve you in deciding with the teacher 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 concern 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 |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Serious blows to head | <input type="checkbox"/> (more than 2 per year) |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Headaches | <input type="checkbox"/> Overtired or lacking pep |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Nightmares | <input type="checkbox"/> Heart trouble |
| <input type="checkbox"/> Stomachaches | <input type="checkbox"/> Thumb sucking | <input type="checkbox"/> Hyperactivity |
| <input type="checkbox"/> Frequent fevers | <input type="checkbox"/> Nail biting | <input type="checkbox"/> Medical problems |
| | | <input type="checkbox"/> immediately after birth |
| <input type="checkbox"/> Sinus trouble | <input type="checkbox"/> Epilepsy (seizures) | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Nose bleeding | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Substance abuse victim |

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 this child ever had any ear/hearing examination or treatment (mark one) Yes _____ No _____

When _____ By whom _____
Results _____

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

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
Do you suspect any vision problem?	_____	_____
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?	_____	_____
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 others?	_____	_____

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. 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 staff social worker to relate any information you don't feel you can include on this form? _____

Thank you for your patience in filling out this questionnaire.