

**ST. SEBASTIAN SCHOOL
500 MULL AVENUE
AKRON, OHIO 44320
330-836-9107**

**EARLY PREVENTION OF SCHOOL FAILURE
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 of 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.

1. General Health History

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

Asthma	Bed Wetting	Loss of consciousness
Indigestion	Allergies	Chronic ear infection (more than 2 per year)
Constipation	Serious blows to head	
Diarrhea	Headaches	Overtired or lacking pep
Vomiting	Nightmares	Heart trouble
Stomachaches	Thumbsucking	Hyperactivity
Frequent fevers	Nail biting	Medical problems Immediately after birth
Sinus trouble	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 this ever had any ear/hearing examination or treatment?
(Mark only one)

_____ Yes _____ No

When? _____ By Whom _____

Results _____

	YES	NO
A. Do you suspect any hearing problems?	_____	_____
B. 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:

1. Stutter? _____ Yes _____ No
2. 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 _____

Result _____

A. Do you suspect vision problem?

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 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. Loss balance, trip and fall more often than “normal”?
4. Have difficulty running?

VI. Social Development

Does your child:

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

Thank you for your patience in filling out this questionnaire.