

BELMONT PUBLIC SCHOOLS

PARENT INTERVIEW FORM

Background

Child's Name: _____

What would your child like to be called? _____

Male ___ Female ___ Child's Birth Date: _____
Month Day Year

Street Address: _____

Telephone Number: _____

Parent/Guardian # 1 Name: _____

Home Address: _____

Home Telephone Number: _____

Work Telephone Number: _____

Cell Phone Number: _____

Parent/Guardian # 2 Name: _____

Home Address: _____

Home Telephone Number: _____

Work Telephone Number: _____

Cell Phone Number: _____

Parents' Marital Status: Married _____ Separated _____ Divorced _____ Single _____

Has either parent remarried? _____

Stepparent's Name: _____

Who else lives in child's home? _____ Relationship _____

Names and ages of Siblings: (Please include half and step brothers and sisters.)

Name: _____ Age: _____ Name: _____ Age: _____

Name: _____ Age: _____ Name: _____ Age: _____

Language spoken in the home _____

Child's dominant language _____

Was there anything unusual about the pregnancy with your child? _____

Weight at birth: _____ lbs. _____ oz. Was your child adopted? _____

Has your child ever required medical attention for a serious illness or accident? _____

Is your child presently on any medication? If yes please explain. _____

Has your child received special services/intervention? Please describe: _____

Does your child have any allergies? _____

Have there been any previous private or public school screenings or evaluations: Please describe: _____

Have **siblings** required special services/intervention? Please describe: _____

Milestone

Did your pediatrician have any developmental concerns? _____

Is your child toilet trained? Yes _____ No _____

Hearing

YES

NO

Has your child had any history of ear infections?

Has your child ever had a hearing examination?

If yes, results: _____

Does your child:

YES

NO

1. Display difficulty in hearing?

2. Favor one ear over another?

3. Appear to be sensitive to loud noises?

4. Seem to have difficulty understanding what you say?

5. Seem to have difficulty understanding what other children say to him/her?

6. Seem to have difficulty following directions?

Vision

YES

NO

Does your child have any difficulty with vision?

If yes, describe: _____

Does your child:

1. Seem to have difficulty seeing small pictures?

2. Seem to have trouble seeing things far away?

3. Wear glasses?

4. Have a "lazy eye"?

Do we have permission to speak with your child's preschool school teacher? Yes ___ No ___

Please attach a copy of your child's most recent preschool progress report.

Do you have any special concerns about your child? Yes ___ No ___

Do you have any information you feel would be helpful for us to know about your child?

Form completed by: _____ Date: _____
(Please print)

Signature: _____ Date: _____

Relationship to child: _____

Thank you for your time in completing this questionnaire!