

## EDUCATIONAL SCREENING/EXISTING EVALUATION DATA

Student Name:	Grade:
Date of Birth:	Sex:
Campus/Scl    Itasca ISD	S.S. #:

### INFORMATION FROM PARENTS/ADULT STUDENT

		Student's parents have been contacted. Method of contact:			
YES	NO		Letter	Telephone	Conference

Contacted by (school staff person) _____	Position: _____
The following information was obtained from: _____	

**GENERAL INFORMATION** (If additional space is needed, please use the back of this page.)

Father's Name	Occupation	Home Phone Number
Mother's Name	Occupation	Home Phone Number

What is your current address? \_\_\_\_\_

Who has legal authority to make educational decisions for this child? \_\_\_\_\_

With whom does this student live? \_\_\_\_\_

OTHER CHILDREN IN THE HOME:		
Name	Age	Relationship

OTHER ADULTS IN THE HOME:		
Name	Age	Relationship

Please describe your child's behavior at home. (For example, is he / she generally well-behaved? Have there been any recent changes in behavior? How does he / she get along with other family members, neighbors, and playmates?)

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What are some of your child's strengths?

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What activities does the family do together? (For example, watch TV, go camping, participate in hobbies or sports.)

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What does your child do when not in school? For example, watch TV, read, part-time job, play with other children.)

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Have any family members had learning problems?  
Please explain:

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Have there been any important changes within the family during the last 3 years? (For example, job changes, moves, births, deaths, illnesses, separations, divorce.)

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Do you feel that your child is experiencing problems in school? What kinds of problems?

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When were you first aware of a problem?

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What do you think is causing the problem?

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Briefly discuss any other important information about your child:

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Primary language spoken at home: \_\_\_\_\_  
What language does your child speak most of the time?

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What time does your child go to bed at night? \_\_\_\_\_

Does your child usually eat breakfast? \_\_\_\_\_

What methods of discipline are used with your child at home? (For example, spanking, extra chores, early bedtime, rewards for good behavior.)

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What is your child's reaction to discipline?

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Has your child mentioned any problems with school? How does he / she feel about the problem?

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**HEALTH HISTORY:**

YES

NO

Were there any problems before, during, or immediately after birth? If YES, please explain:

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Briefly describe any serious illnesses, accidents or hospitalizations. Please give your child's age at the time of the illness, accident, or hospitalization.

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YES

NO

Does your child appear to have any other physical health problems, including allergies? If YES, explain:

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YES

NO

Does your child use any special equipment or technology to improve functioning? If YES, Explain:

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YES

NO

Is your child receiving services from another agency? If YES, explain:

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YES

NO

Would you like to speak to the person coordinating your child's assessment **before** testing begins?

Compared to other children in the family, this child's development has been:

slower

about the same

faster

YES

NO

Is your child under the care of a physician for a medical problem? If YES, explain:

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YES

NO

Is your child now taking any medications? If YES, explain:

YES

NO

Do you know of any side effects the medication might have? If YES, explain:

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YES

NO

Has your child ever taken medicine for a long period of time? If YES, explain:

YES

NO

Are there any family health concerns you would like us to be aware of at this time? If YES, explain:

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Signature of Parent

DATE