

**KINDERGARTEN/NEW GRADE 1  
STUDENT INFORMATION FORM B**

Name of Child: \_\_\_\_\_

D.O.B: \_\_\_\_\_

Teacher's Name: \_\_\_\_\_

Father's Name: \_\_\_\_\_

Age: \_\_\_\_\_ Occupation: \_\_\_\_\_

Father's Highest Level of Education: \_\_\_\_\_

was academic assistance needed? \_\_\_\_\_ Yes \_\_\_\_\_ No

Address: \_\_\_\_\_

Mother's Name: \_\_\_\_\_

Age: \_\_\_\_\_ Occupation: \_\_\_\_\_

Mother's Highest Level of Education: \_\_\_\_\_

was academic assistance needed? \_\_\_\_\_ Yes \_\_\_\_\_ No

Address: \_\_\_\_\_

<u>Names of Siblings</u>	<u>Age</u>	<u>Gender</u>	<u>Speech, language or learning concerns?</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Are there other individuals living in the home? \_\_\_\_\_ Relationship to the child? \_\_\_\_\_

**GENERAL INFORMATION**

What kind of literature does your child enjoy? \_\_\_\_\_

Would you like any information about adult literacy? (i.e. GED) \_\_\_\_\_ Yes \_\_\_\_\_ No

Have there been any changes in your child's life recently (i.e. birth of sibling, divorce, death) \_\_\_\_\_

Are there any agencies/ programs assisting your child or family at this time? (i.e. Headstart, Systems of Care, LEARN) \_\_\_\_\_

Please include any additional information that will help us understand and better provide an optimal educational program for your child. \_\_\_\_\_

Would you like to schedule an individual conference with a school counselor to discuss any information you felt you could not include on this questionnaire or to elaborate on any information you included above?

\_\_\_\_\_ Yes (please contact me so we can discuss my child's program needs further)

\_\_\_\_\_ No (I do not wish to schedule a meeting at this time)

**MEDICAL INFORMATION:**

Have there been any changes in your child's medical history since you completed the registration packet? \_\_\_\_\_ Yes \_\_\_\_\_ No

Explain: \_\_\_\_\_

**VISION INFORMATION**

Has your child ever had an eye examination? \_\_\_\_\_ Yes \_\_\_\_\_ No

WHEN: \_\_\_\_\_ BY WHOM: \_\_\_\_\_

Does your child wear glasses? \_\_\_\_\_ Yes \_\_\_\_\_ No

Do you think your child has trouble seeing? \_\_\_\_\_ Yes \_\_\_\_\_ No Explain: \_\_\_\_\_

**PLEASE COMPLETE BACK OF FORM**

**HEARING INFORMATION**

Has your child ever had a hearing test?  Yes  No WHEN: \_\_\_\_\_ BY WHOM: \_\_\_\_\_

Do you think your child has any hearing problems?  Yes  No

Explain: \_\_\_\_\_

Does your child have a history of middle ear infections/fluid?  Yes  No

Has your child seen an ear, nose and throat doctor?  Yes  No if "yes" name of doctor: \_\_\_\_\_

Do any family members have a history of middle ear problems or a hearing loss?  Yes  No If "yes" whom? \_\_\_\_\_

Has your child been treated for any of these ear/hearing problems?

Eustachian tube dysfunction  YES  NO WHEN \_\_\_\_\_

Fluid in the ears  YES  NO WHEN \_\_\_\_\_

Wax build-up  YES  NO WHEN \_\_\_\_\_

Ruptured ear drum  YES  NO WHEN \_\_\_\_\_

Hearing loss  YES  NO WHEN \_\_\_\_\_

Has your child had any of these surgical procedures?

Tonsillectomy  YES  NO WHEN \_\_\_\_\_

Adenoidectomy  YES  NO WHEN \_\_\_\_\_

Myringotomy with tubes  YES  NO WHEN \_\_\_\_\_

Tympanoplasty (eardrum graft)  YES  NO WHEN \_\_\_\_\_

Does your child have any known allergies?  YES  NO

Does your child have an allergy doctor?  YES  NO

Allergies: \_\_\_\_\_ Doctor: \_\_\_\_\_

Please provide more detailed information regarding your child's hearing history if necessary.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name of parent/ guardian completing this form: \_\_\_\_\_

Telephone number: \_\_\_\_\_