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: _____

Names of Siblings	Age	Gender	Speech, language or learning concerns?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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: _____