Parent Background Information

Child’s name: Date of Birth:

Educational History:

Please list all schools this child attended and in which grades (include preschool):

Medical History:

Does this child wear glasses? \_\_\_\_\_\_\_ Hearing aid(s)? \_\_\_\_\_\_\_\_\_\_\_\_

Do you suspect this child has problems with vision or hearing?

When is the last time this child saw the doctor?

Does the child have any health problems or concerns of which you are aware?

Does the child take any medication? If so, what medication for what purpose?

Who lives in the same home as this child? (Please include ages of other children)

What is this child’s bedtime?

What does this child like to do for fun?

Describe any specific home factors that might affect the child’s performance in school.

What would you like to see for your child’s future?

Describe any other pertinent information not included above. Feel free to use the back of this page.

Print Parent/Guardian Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_