

Southern Local Schools
Salineville, Ohio 43945

Early Prevention of School Failure
Parent Observation Form

Name of Child: _____

Birthdate: _____

Relationship to Child: _____

Please answer the questions on these forms in the best way that you can. You will be able to answer some quite easily and you will have difficulty in making a decision on others. Your answers on this form will help the school staff decide with you and the teacher what kind of educational program is best suited for your child.

These questionnaires are confidential and your responses will be shared only with professional personnel and only if the information learned will help in planning an educational program for your child.

Child's Name: _____ Birthdate: _____

PLACE AN X ON THE BEST ANSWER

YES NO

Has this child ever had any ear/hearing examination or treatment: (Mark one) _____

When? _____ Who? _____ Results _____

Do you suspect hearing problems? _____

Does this child:

1. Seem to have difficulty hearing? _____
2. Turn up the TV louder than other members of the family? _____
3. Seem to favor one ear over the other? _____
4. Jump or appear to be more startled than others if there is a Sudden noise? _____
5. Seem to hear you if you talk in a whisper? _____
6. Make you talk loudly or repeat frequently? _____

Has this child ever had a vision examination or treatment? (Mark one) _____

When? _____ Who? _____ Results _____

Do you suspect any vision problems? _____

Does this child:

1. Seem to have difficulty seeing small lines or pictures? _____
2. Seem to have a problem seeing things far away? _____
3. Squint? _____
4. Have eyes that turn in? _____
5. Have eyes that turn out? _____
6. Sit very close to television? _____
7. Rub eyes a lot? _____

Child's Name: _____ Birthdate: _____

At what age did this child first begin to speak? Give approximate age if you do not remember exact age:

First words: _____ Two or three words together: _____ Sentences: _____

Does this child stutter? _____

This child began walking at age (if guess, label as such) Age: _____

Do you feel that your child have adequate muscle coordination? _____

Please check Yes, Sometimes, No, or Not Sure for each of the following questions:

It is my (our) opinion that this child:	YES	SOMETIMES	NO	NOT SURE
1. Has regular playmates the same age.	_____	_____	_____	_____
2. Has difficulty getting along with other children.	_____	_____	_____	_____
3. Has difficulty expressing self.	_____	_____	_____	_____
4. Prefers to play with other children instead Of alone.	_____	_____	_____	_____
5. Is difficult to understand when talking.	_____	_____	_____	_____
6. Seems generally happy.	_____	_____	_____	_____
7. Is frequently irritable or moody.	_____	_____	_____	_____
8. Is upset by change in routine.	_____	_____	_____	_____
9. Demands much individual adult attention.	_____	_____	_____	_____
10. Accepts discipline and limits.	_____	_____	_____	_____
11. Becomes confused in following two verbal Directions at a time.	_____	_____	_____	_____
12. Has difficulty remembering things for a Long time.	_____	_____	_____	_____

Child's Name: _____ Birthdate: _____

- 13. Has difficulty remembering things for a Short time. _____
- 14. Is easily frustrated. _____
- 15. Cries easily. _____
- 16. Cooperates willingly. _____
- 17. Has a bad temper. _____
- 18. Can use a fork and spoon without help. _____
- 19. Can catch a ball thrown to him. _____
- 20. Enjoys physical activities. _____
- 21. Loses balance, trips and falls. _____
- 22. Has difficulty running. _____
- 23. Is dealing with family stress, such as illness, Death, or separation. _____
- 24. Did your child attend a pre-school? _____

If yes, number of years: _____ Name of school: _____

Number of Brothers: _____ Ages: _____ Number of sisters: _____ Ages: _____

How old are this child's favorite playmates? _____

What kind of things do you like to do with child? _____

Is there any other information that will help us understand this child?

Thank you for your patience in filling out this questionnaire.