The Intervention Support Team requests that the parent or guardian of the student named below completes this form as part of the process of determining the student’s eligibility for learning disability screening. The information provided by the parent or guardian will contribute to the Intervention Support Team’s consideration of all contributing factors that may or may not be related to a specific learning disability.

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| **I. Demographic Information** |
| Student Name: |  | Grade: |  | Date of Birth: |  |
| Mother’s Name: |  | Father’s Name: |  |
| Child Resides With (Name): |  | Relationship: |  |
| Who is Completing this Form? |  | Relationship: |  |
| Who has legal custody or guardianship of this child (please check)?  |
| Mother: |  | Father: |  | Joint: |  | Other (Name & Relationship): |  |
| Please list the names, ages, and relationship to the this child of all others living in the household. |
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| **II. Medical and Developmental History** |
| 1. Describe any medical problems the mother experienced during pregnancy (health, illness, injury, medication). |
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| 2. Describe any medical problems the mother experienced during labor or delivery. |
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| 3. Was the pregnancy full term? | Yes |  | No |  | How many weeks? |  |
| 4. Did this child meet his/her developmental milestones (check): | Early? |  | Late? |  | On Time? |  |
| 5. Please list the approximate age at which this child mastered the following developmental skills. |
| **Skill** | **Age, Years** | **Age, Months** | **Skill** | **Age, Years** | **Age, Months** |
| Sat up Without Help |  |  | Walked Independently |  |  |
| Spoke Single Words |  |  | Spoke Using 2-3 Words |  |  |
| Toilet Trained, Days |  |  | Toilet Trained, Nights |  |  |
| 6. Please list any significant medical information pertaining to this child. Include such things as serious illnesses, injuries, hospitalizations, frequent ear infections, tubes in the ears, hearing problems, seizures, allergies, etc. |
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| 7. Please list any medications this child is currently taking. |
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| 8. Has this child ever had visual problems or worn glasses? | Yes |  | No |  |
| 9. Has this child ever received services for developmental and/or communication delays? | Yes |  | No |  |
| * If so, when and where?
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| 10. Has this child ever had a psychological or psycho-educational evaluation? | Yes |  | No |  |
| * If so, when and where?
 |  |
| 11. Has this child ever received special education service in the past? | Yes |  | No |  |
| * If so, when and where?
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| 12. Please describe any behavior problems you noticed at home or were reported to you by teachers. |
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| **III. Home/Community** |
| 1. Please describe your child’s successes. What is he or she good at or do well? |
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| 2. What are your child’s challenges? What sorts of things does he or she seem to have trouble doing? |
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| 3. Please list your child’s hobbies and any sports or other organized activities he or she is involved in. |
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| 4. How does your child get along with adults? He does he or she get along with his/her peers. |
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| 5. Have there been recent changes at home that may be impacting your child’s performance at school? |
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