The Immaculate Conception School 112 Ware Avenue, Towson, MD 21204

Parent Observation Form

Please return this form with application and health forms.

Name of Child _____ Gender: M F Birth Date _____

Child's Nickname *(if applicable)* _____

Child's present school_____

School address _____ School phone _____

Parent/s name _____

Daytime phone _____ Home phone _____ Cell phone _____

Home address _____

Mother's place of business and occupation _____

Father's place of business and occupation _____

Child's siblings (names and ages) _____

Please answer the questions on this form in the best way that you can. You will be able to answer some quite easily, and you may have difficulty in making a decision on others. This questionnaire is confidential and your responses will be shared only with professional staff.

GENERAL HEALTH HISTORY *(please check any that you or your child's physician have observed):*

___ Asthma	___ Bed-wetting	___ Loss of consciousness	___ Indigestion
___ Allergies	___ Overtired	___ Thumb sucking	___ Constipation
___ Headaches	___ Diarrhea	___ Serious blows to head	___ Vomiting
___ Heart trouble	___ Hyperactivity	___ Substance abuse victim	___ Nightmares
___ Stomachaches	___ Nose bleeds	___ Chronic ear infections	___ Fainting
___ Frequent fevers	___ Diabetes	___ Medical problems at birth	___ Nail biting
___ Epilepsy (seizures)	___ Sinus problems		

___ Other physical problems (explain) _____

_____

At what age did your child become fully potty trained? _____

**Please note all children must be fully potty trained before school begins*.

Is your child currently on medication? ___ yes ___ no

If yes, please list med/s_____

Were there any unusual circumstances surrounding the pregnancy or birth of your child? ___ yes ___ no

If yes, please explain _____

Has your child had any significant injuries or hospitalization? ___ yes ___ no

If yes, please explain _____

HEARING ASSESSMENT

Has your child ever had any ear/hearing examination or treatment? ___ yes ___ no

When? _____ By whom? _____

Results _____

Do you suspect any hearing problems in your child? ___ yes ___ no

Does your child:

- Turn up the TV louder than other family members? ___ yes ___ no
- Seem to favor one ear over the other? ___ yes ___ no
- Jump or appear to be more startled than others if there is a sudden noise? ___ yes ___ no
- Seem to have difficulty hearing? ___ yes ___ no
- Have difficulty hearing you if you talk in a whisper? ___ yes ___ no
- Make you talk loudly or repeat frequently? ___ yes ___ no
- Become confused in following more than two verbal directions at a time? ___ yes ___ no
- Have difficulty remembering things for a long time? ___ yes ___ no
- Have difficulty remembering things for a short time? ___ yes ___ no

LANGUAGE DEVELOPMENT

At what age did your child first begin to speak *(give approximate age if you do not remember exact age)*? _____

First words spoken _____ Two or three words together _____

Sentences _____

Does your child stutter? ___ yes ___ no

Does your child have difficulty expressing ideas and concepts? ___ yes ___ no

VISUAL ASSESSMENT

Has your child had a vision examination or treatment? ___ yes ___ no

When? _____ By whom? _____

Results _____

Do you suspect any vision problem? ___ yes ___ no

Does your child:

- Seem to have difficulty seeing small lines or pictures? ___ yes ___ no
- Seem to have a problem seeing things far away? ___ yes ___ no
- Squint? ___ yes ___ no
- Wear glasses? ___ yes ___ no
- Have eyes that turn in? ___ yes ___ no
- Have eyes that turn out? ___ yes ___ no
- Sit very close to the TV? ___ yes ___ no
- Rub eyes a lot? ___ yes ___ no
- Turn head so as to use one eye primarily? ___ yes ___ no
- Lower one side of the head when looking at others? ___ yes ___ no

MOTOR DEVELOPMENT

At what age did your child begin walking? (if a guess, please label as such) _____

Do you feel your child has adequate large muscle coordination? ___ yes ___ no

Does your child:

- Catch a ball thrown to her/him? ___ yes ___ no
- Enjoy physical activities? ___ yes ___ no
- Lose balance, trip and fall more often than "normal"? ___ yes ___ no
- Have difficulty running? ___ yes ___ no

SOCIAL DEVELOPMENT

Does your child:

- Have regular playmates the same age? ___ yes ___ no
- Have difficulty getting along with other children? ___ yes ___ no
- Prefer to play with other children instead of alone? ___ yes ___ no
- Become easily frightened? ___ yes ___ no
- Cry often? ___ yes ___ no
- Have a bad temper? ___ yes ___ no
- Enjoy cooperating with others? ___ yes ___ no
- Become frequently irritated or moody? ___ yes ___ no
- Become upset by changes in routine? ___ yes ___ no
- Have extreme difficulty dealing with family stressors? ___ yes ___ no
- Demand much individual adult attention? ___ yes ___ no
- Accept discipline and limits? ___ yes ___ no

Is there any other information that will help us better understand your child? _____
_____
_____

Has your child attended a preschool? ___yes ___no Number of years _____

Does your child know how to read? ___yes ___no

Does your child know how to write? ___yes ___no

At what age did your child become fully potty trained? _____

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