School District 78
Fraser-Cascade

650 Kawkawa Lake Road, Hope, B. C. V0X 1L4

Student Services
Phone (604) 869-2411
Fax (604) 869-7400

CONFIDENTIAL

PARENT INFORMATION FORM

GENERAL INFORMATION

Parent/Guardian Name:_____ Child's Name:_____

DOB:_____ Grade:_____ Today's date:_____

Address:_____Phone:_____

Your child has been selected for a psycho-educational assessment. Your background knowledge about your child is important to the assessment process.

Does your child have siblings? If so please list names and ages:_____
_____
_____
_____

What is your child's dominant hand? ____Right _____left _____not established

PREGNANCY/BIRTH

1. Were there any problems during pregnancy? _____yes _____no
   If yes please explain:_____
   _____
   _____

2. Were there any complications during the delivery or soon after?
   If yes please explain: _____
   _____
   _____
   _____
   _____

INFANCY/EARLY CHILDHOOD DEVELOPMENT

1. **Motor development**: Did your child have any motor/movement based delays (i.e., sitting, crawling, standing, walking, riding a bike, etc)? _____yes _____no

If so, what were the specific delays?

_____
_____
_____
_____
_____

2 **Speech and language development**: Did your child have any language delays (i.e., did it take a relatively long time to name objects or people, or did he/she have trouble in forming sentences)? _____yes _____no

If so, what were the specific delays?

_____
_____
_____
_____
_____

3. Were there any concerns about swallowing or feeding? _____yes _____no

_____

4. Hospitalizations during infancy/childhood? _____yes _____no
If yes please explain: _____
_____
_____
_____

5. Has you child ever had any accidental head injuries that required a visit to the doctor or hospital? (e.g. from a fall, car accident, etc.) _____yes _____no
If yes please explain:_____
_____
_____
_____

6. Has your child had ear infections? If so, about how many and how were they treated?
_____
_____
_____
_____

7. Does your child wear glasses? _____yes _____no

8. Does your child take any prescription or nonprescription medication? If so, what is the medication, what is the dosage and how long has your child been taking the medication?_____
_____

PROGRAMS/SCHOOLING

1. Did your child attend preschool? _____yes _____no.

2. Has your child received services in the following areas:

Child infant development program	_____yes	_____no
Speech therapy	_____yes	_____no
Occupational therapy	_____yes	_____no
Physiotherapy	_____yes	_____no
Audiological assessment	_____yes	_____no
Vision examination	_____yes	_____no
Special program placement	_____yes	_____no

3. Are there any other health issues the school should be aware of regarding your child?
_____yes _____no

   If yes please explain:_____

4. What does your child do well?_____

5. What does your child tend to avoid?_____

6. Is there anything specific you would like to come from this assessment?

_____
Signature of Person completing the questionnaire

_____ _____
Relationship to Child Date