Saint Ambrose Catholic School
A U.S. Department of Education School of Excellence

Kindergarten Parent Observation Form

Name of Child _____ Birthdate _____

Parent Name _____

Preferred Phone Number _____

Address _____

Occupation:

Father _____

Mother _____

Child's Family Includes:

Brothers (Names and Ages)		Sisters (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. Your answers on this form will assist the school in deciding what kind of educational program is best suited for your child.

This questionnaire is confidential and your responses will be share only with the professional personnel and only if the information learned will help in planning an educational program for your child.

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U.S. Department of Education Blue Ribbon Schools Program 2010

I. GENERAL HEALTH HISTORY

Please check any health concerns that you or your doctor observed:

_____ Asthma	_____ Bed Wetting	_____ Loss of consciousness
_____ Indigestion	_____ Allergies	_____ Chronic ear infections (more than two per year)
_____ Constipation	_____ Serious blow to head	_____ Overtired or lacking pep
_____ Diarrhea	_____ Headaches	_____ Heart trouble
_____ Vomiting	_____ Nightmares	_____ Hyperactivity
_____ Stomachaches	_____ Thumb sucking	_____ Medical problems (immediately after birth)
_____ Frequent fevers	_____ Nail biting	_____ Substance abuse victim
_____ Sinus trouble	_____ Epilepsy (seizures)	_____ Fainting
_____ Nose bleeding	_____ Diabetes	

_____ Other physical problems (please explain):

_____

_____

Is this child presently on medication? Yes No (circle one)

What? _____

Has child had any significant injuries or hospitalization? _____

_____

Is child "healthy" on day of assessment? _____

_____

Has your child attended preschool?

# of years _____

Does your child know how to read? Yes No Does your child know how to write? Yes No

II. HEARING ASSESSMENT

Has this child ever had any ear/hearing examination or treatment? Yes No (circle one)

When? _____ By Whom? _____

Results: _____

II. HEARING ASSESSMENT Continued

	Yes	No
A. Do you suspect any hearing problems?	_____	_____
Does your 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?	_____	_____
7. Become confused in following more than two verbal directions at a time?	_____	_____
8. Have difficulty remembering things for a long time?	_____	_____
9. Have difficulty remembering things for a short time?	_____	_____

III. LANGUAGE DEVELOPMENT

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

First words _____

Two or three words together _____

Sentences _____

Does your child:	Yes	No
Stutter?	_____	_____
Have difficulty expressing ideas and concepts?	_____	_____

IV. VISUAL ASSESSMENT

Has your child ever had a vision examination or treatment? Yes No (circle one)

When? _____ By Whom? _____

Results _____

	Yes	No (circle one)
A. Do you suspect any vision problems?		
B. Does your child:		
1. Seem to have difficulty seeing small lines or pictures?	_____	_____
2. Seem to have a problem seeing things far away?	_____	_____
3. Squint?	_____	_____
4. Wear glasses?	_____	_____
5. Have eyes that turn in?	_____	_____
6. Have eyes that turn out?	_____	_____
7. Sit very close to televisions?	_____	_____

VISUAL ASSESSMENT Continued

	Yes	No
8. Rub eyes a lot?	_____	_____
9. Turn head as to use primarily one eye	_____	_____
10. Lower one side of the head when looking at others?	_____	_____

V. MOTOR DEVELOPMENT

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

	Yes	No
Do you feel your child has adequate large muscle coordination	_____	_____

Does your child:

1. Catch a ball thrown to him?	_____	_____
2. Enjoy physical activities?	_____	_____
3. Lose balance, trip and fall more often than normal?	_____	_____
4. Have difficulty running?	_____	_____

VI. SOCIAL DEVELOPMENT

Does your child:	Yes	No
1. Have regular playmates the same age?	_____	_____
2. Have difficulty getting along with other children?	_____	_____
3. Prefer to play with other children instead of alone?	_____	_____
4. Become easily frustrated?	_____	_____
5. Cry often?	_____	_____
6. Have a bad temper?	_____	_____
7. Enjoy cooperating with others?	_____	_____
8. Become frequently irritated or moody?	_____	_____
9. Become upset by changes in routine?	_____	_____
10. Have difficulty dealing with family stress such as illness, death, or separation?	_____	_____
11. Demand much individual adult attention?	_____	_____
12. Accept discipline and limits?	_____	_____

VII. OTHER INFORMATION

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

_____

_____