

PROVO SCHOOL DISTRICT

October 4, 1999

Parental Referral for Assistance Interview Form

As part of this Parental Referral the student's classroom teacher is required to complete and submit the Provo School District At-Risk Intervention Documentation form.

STUDENT BACKGROUND INFORMATION

Name of Student _____ Sex _____ Birthdate _____
Address _____ City _____ Phone _____
School _____ Grade _____ Teacher _____

TASK DEVELOPMENT:

At what age did your child ...?

Sit _____ Walk _____ Start Talking _____
Toilet Train/Day _____ Toilet Train/Night _____ Special Concerns _____

MEDICAL HISTORY:

Family Doctor _____ Date of Last Physical Exam _____
Date of Last Vision Exam? _____ By Whom? _____ Results _____

HAS YOUR CHILD EVER HAD: (If Yes, List # and Comments)

YES NO

- | | | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Any Allergies? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Any Hearing Problems? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Any Speech Problems? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Heart Disease or Murmur? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Kidney Disease? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Seizures? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. Diabetes? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 8. Any Serious or Chronic Disease? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 9. Difficulty with Motor Coordination? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 10. Any Emotional Problems? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 11. Any Operations or Hospitalizations? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 12. Any Serious Accident? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 13. Does, or Has, Your Child Tired Easily? _____ |

List Family Medical or Learning Problems _____

How many siblings are there in the home? _____ What is your child's place in the family? _____

Describe Sleeping Pattern _____

Describe Discipline Pattern _____

Is your child on Special Medication? ____ What? _____ When? _____
Why? _____

How would you describe your child's present health? _____

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

SOCIAL HISTORY:

Does Your Child: Live with both parents? _____ If not, which one? _____
Have any annoying habits? _____ What? _____
Watch television? _____ Time daily _____
Read to you? _____ Time daily _____
Get read to? _____ Time daily _____
Plan cautiously? _____ Impulsively? _____
Have home responsibilities? _____ What? _____
Take part in family activities? _____ What type? _____

Has Your Child: Been separated (explain) for any length of time from
Father: _____
Mother: _____
Experienced death of a close relative _____ friend _____ or pet _____

School: Favorite subjects _____ Least favorite _____
Repeat grade _____ Skipped grade _____
Previous Schools _____
Programs _____
Agencies _____
Feelings of child about teacher _____
Feelings of child about peers _____
Feelings of child about school _____

Have you reported any concerns to your child's classroom teacher? Yes No
If yes, please describe what you reported and the action taken: _____

Has your child's classroom teacher reported any concerns to you? Yes No
If yes, please describe what action was taken: _____

Comments: _____

Parent(s) Signature Date