Southern Local Schools
Salineville, Ohio 43945

Early Prevention of School Failure
Parent Observation Form

Name of Child: ____

Birthdate: _______________________________________

Relationship to Child: ____

Please answer the questions on these forms in the best way that you can. You will be able to answer some quite easily and you will have difficulty in making decision on others. Your answers on this form will help the school staff decide with you and the teacher what kind of educational program is best suited for your child.

These questions are confidential and your responses will be shared only with professional personnel and only it the information learned will help in planning an educational program for your child.

Child's Name: ____ Birthdate: _____________

PLACE AN X ON THE BEST ANSWER

	Yes	No
Has this child had any ear/hearing examination or treatment: (Mark one)		

When? ________________ Who? __________ Results ___________________________

Do you suspect hearing problems?		

Does this 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.	Seems to hear you if you talk in a whisper?		
6.	Make you talk loudly or repeat frequently?		

Has this child ever had a vision examination or treatment? (Mark one)		

When? ________________ Who? __________ Results ___________________________

Do you suspect any vision problems?		

Does this child:

1.	Seem to have difficulty seeing small lines or pictures?		
2.	Seem to have a problem seeing things far away?		
3.	Squint?		
4.	Have eyes that turn in?		
5.	Have eyes that turn out?		
6.	Sit very close to television?		
7.	Rub eyes a lot?		

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

First words: ______________ Two or three words together: ______________ Sentences: ______________

Does this child stutter?		

This child began <u>walking</u> at age (if guess, label as such) Age: ____________________________

Child's Name: ____ Birthdate: _____________

Do you feel that your child has adequate muscle coordination?		

Please check Yes, Sometimes, No, or Nor Sure for each of the following questions:

It is my (our) opinion that this child:	YES	SOMETIMES	NO	NOT SURE
Has regular playmates the same age.				
Has difficulty getting along with other children.				
Has difficultly expressing self				
Prefers to play with other children instead of alone				
Is difficult to understand when talking.				
Seems generally happy.				
Is frequently irritable or moody.				
Is upset by change in routine.				
Demands much individual adult attention.				
Accepts discipline and limits.				
Becomes confuse in following two verbal directions at a time.				
Has difficultly remember things for a long time.				
Has difficulty remember things for a short time.				
Is easily frustrated.				
Cries easily.				
Cooperates willingly.				
Has a bad temper.				
Can use a fork and spoon without help.				
Can catch a ball thrown to him.				
Enjoys physical activities.				
Loses balance, trips and falls.				
Has difficulty running.				
Is dealing with family stress, such as illness, death or separation.				
Did your child attend a pre-school?				

If yes, number of years: __________ Name of school: ____

Child's Name: ____ Birthdate: _____________

Number of Brothers: _________ Ages: ___________ Number of sisters: _________ Ages: ____________

How old are this child's favorite playmates? _________________________

What kind of things do you like to do with child? ____

Is there any other information that will help us understand this child?

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Thank you for your patience in filling out this questionnaire.