





How did you come to know about Immanuel? Friends/relatives \_\_\_\_\_  
Outdoor sign \_\_\_\_\_ Brochure \_\_\_\_\_ Other(specify) \_\_\_\_\_

Preferred visit with homeroom teacher August 2019 In School \_\_\_\_\_ Home \_\_\_\_\_  
Directions to house for home visit \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### CHILD DEVELOPMENT AND FAMILY INFORMATION

1. Pregnancy: Full term \_\_\_\_\_ Normal \_\_\_\_\_ Complications \_\_\_\_\_ (Please give details) \_\_\_\_\_  
\_\_\_\_\_

2. As a baby; was he/she curious? \_\_\_\_\_ Busy \_\_\_\_\_ Fussy \_\_\_\_\_ Quiet \_\_\_\_\_  
Passive \_\_\_\_\_ Alert \_\_\_\_\_

3. At what approximate age did your child: Creep \_\_\_\_\_ Sit Alone \_\_\_\_\_  
Talk: Words \_\_\_\_\_ Sentences \_\_\_\_\_

4. Has your child ever been tested for a learning disability? Yes \_\_\_\_\_ No \_\_\_\_\_  
If so, where? \_\_\_\_\_

Has your child ever been tested for Attention Deficit Hyper Activity Disorder?  
Yes \_\_\_\_\_ No \_\_\_\_\_ Explain: \_\_\_\_\_

Vision: Wears glasses: Yes \_\_\_\_\_ No \_\_\_\_\_ Hearing Aid: Yes \_\_\_\_\_ No \_\_\_\_\_  
Speech defects? Regular Medication: Yes \_\_\_\_\_ No \_\_\_\_\_

Name of Medication: \_\_\_\_\_

Allergies: Yes \_\_\_\_\_ No \_\_\_\_\_

Explain: \_\_\_\_\_

Seizures: Yes \_\_\_\_\_ No \_\_\_\_\_

Explain: \_\_\_\_\_

Give a brief history of serious accidents, illness, broken bones, operations or special examinations, if health problems require restricted activity or special attention:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5. Are there any physical defects which would limit your child's participation in school or school related activities? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please explain \_\_\_\_\_  
\_\_\_\_\_

6. How long does he/she sleep at night? \_\_\_\_\_

7. Have there been any concerns regarding sleep? (Explain i.e. duration, night terrors)  
\_\_\_\_\_  
\_\_\_\_\_

8. Does your child have problems waking up? \_\_\_\_\_

9. Does your child have a good appetite? \_\_\_\_\_

10. Does he/she often seem listless and tired? \_\_\_\_\_
11. Are there any nervous habits? \_\_\_\_\_ If yes, please explain \_\_\_\_\_  
\_\_\_\_\_
12. Which hand does your child show a preference for? \_\_\_\_\_
13. Does he/she have any fears? \_\_\_\_\_ If yes, please explain \_\_\_\_\_  
\_\_\_\_\_
14. Should your child wear glasses? \_\_\_\_\_ When? \_\_\_\_\_
15. How is his/her general cooperation with members of the family? \_\_\_\_\_  
\_\_\_\_\_
16. How well does he/she get along with other children that are younger than himself/herself? \_\_\_\_\_ same age? \_\_\_\_\_ older? \_\_\_\_\_
17. Does he/she play well by himself/herself? \_\_\_\_\_
18. How many playmates does your child have? \_\_\_\_\_ what age? \_\_\_\_\_
19. Is there another person who cares for him/her part of the time? \_\_\_\_\_  
Who? \_\_\_\_\_ How is their relationship? \_\_\_\_\_
20. What is of special interest to your child? \_\_\_\_\_
21. The following items will help us better understand your child and be alert to his/her needs. Please check those which describe your child:
- \_\_\_ Worries      \_\_\_ Self confident      \_\_\_ Enthusiastic      \_\_\_ Self-conscious
- \_\_\_ Bold      \_\_\_ Shy      \_\_\_ Easily discouraged      \_\_\_ Generous
- \_\_\_ Easy going      \_\_\_ Insecure      \_\_\_ Selfish      \_\_\_ Indifferent
- \_\_\_ Daydreams      \_\_\_ Temper outbursts      \_\_\_ Quiet      \_\_\_ Short attention
- \_\_\_ Easily frustrated      \_\_\_ Moody      \_\_\_ Very active      \_\_\_ Carefree
- \_\_\_ Other \_\_\_\_\_ Please give details concerning any of the above characteristics: \_\_\_\_\_
22. Has there been any recent experiences which may have affected your child? (i.e. a recent move to a new home, serious illness, adoption, new jobs, death, divorce, separation) \_\_\_\_\_

Name of person responding \_\_\_\_\_

Relationship \_\_\_\_\_

Signature of parent/guardian \_\_\_\_\_ Date \_\_\_\_\_

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