Background Information Form

Date _____

School _____

Child's name _____ Phone/Cell Phone: _____
Last First Middle

Address _____ City _____ State _____ ZIP _____

Birth date Age _____ Boy ☐ Girl ☐

Race (optional–Circle one or more): Caucasian African-American Hispanic Asian Other _____

Mother's name _____ Place of work _____ Phone _____
Last First Middle Initial

Highest grade completed _____ Mother's age _____

Father's name _____ Place of work _____ Phone _____
Last First Middle Initial

Highest grade completed _____ Father's age _____

Number in family _____ Adults _____ Children _____ Children in school _____

Parents living together: Yes ☐ No ☐ If no, who has legal custody? Mother ☐ Father ☐ Other _____

Names of other schools or programs this child attended:

_____
When attended Name of program Address

_____
When attended Name of program Address

Has your child been tested before or had any special services (like speech-language, physical therapy, developmental preschool)? Yes ☐ No ☐ If yes, please describe:

_____

_____

_____

What language(s) does your child speak at home? _____

What language(s) do parents speak at home? _____

Names and ages of brothers and sisters (oldest child's name first—continue on back [of sheet] if needed):

Name	Age	School	Name	Age	School

Is this child or are any of your other children in the free lunch program? Yes ☐ No ☐

Please tell us any concerns you have about the way your child is learning, developing, or behaving.

_____

_____

_____

_____

Please tell us where you think your child is excelling.

If you have concerns about your child, why do you think he/she may be having difficulties?

What do you find most rewarding and most challenging as a parent?

How often are you able to read to your child: Never ☐ Monthly ☐ Weekly ☐ Several times per week ☐ Daily ☐

How much TV does your child watch per day: 30 minutes ☐ 1 hour ☐ 1½ hours ☐ 2 hours ☐ 3 or more hours ☐

Who gives your child medical care? _____ Address _____

Are your child's immunizations up to date? Yes ☐ No ☐ Not sure ☐

Does your child have any medical conditions or has he/she been hospitalized previously? Yes ☐ No ☐

If yes, please describe:

Is your child taking any medicines? Yes ☐ No ☐ If yes, please indicate:

Name of Drug	Reason for Taking	How much each day?

Results of vision screening? Pass ☐ Fail ☐ Other _____ When? _____

If fail, what recommended services did your child receive? _____

Results of hearing screening? Pass ☐ Fail ☐ Other _____ When? _____

If fail, what recommended services did your child receive? _____

Is there anything else you would like us to know about you or your child? (continue on back if needed)

By signing below, parent understands the information given on the above form.

_____ _____

Parent's Signature Date