

LONG COUNTY SCHOOL SYSTEM
Special Education Department
Background Information
(To be completed by parents or guardian)

Dear Parent: We would appreciate your help in completing this information regarding your child and returning it to the school. The information will help us in working more effectively with your child. Information on this form will be treated in a confidential manner.

Child's Name: _____ Date today: _____
First Middle Last

Address: _____ Birthdate: _____

Name of parent or guardian with whom child lives: _____ Home Phone #: _____

Agencies or specialists that have worked with this child or family:
Mental Health Clinic _____ Family Physician _____ Social Worker _____ Other _____

If any checked, please give the following information:

NAME	TITLE	ADDRESS	DATE SEEN
_____	_____	_____	_____
_____	_____	_____	_____

FAMILY DATA

Mother's Name: _____ Age: _____ Education: (optional) _____

Place of Work _____ Work Phone Number: _____

Father's Name: _____ Age: _____ Education: (optional) _____

Place of Work _____ Work Phone Number: _____

Step-Parent's Name: _____ Age: _____ Education: (optional) _____

Place of Work _____ Work Phone Number: _____

Marital Status of Parents: _____

If parents are separated or divorced, how old was child when the separation occurred? _____

List all people living in household:

Name:	Relationship to Child	Age
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

If any brothers or sisters are living outside the home, list their names and ages:

Name	Age
_____	_____
_____	_____
_____	_____

Did your child attend preschool? If so, name of Pre-K program: _____

SCHOOL HISTORY

Number of years attended this school (circle one): 1 2 3 4 5 6 7 8

Grades Repeated: _____

Other Schools Attended: _____

Describe any serious problems your child has had at school: _____

Describe any serious problems your child has had at home: _____

BIRTH HISTORY

List any illnesses or problems occurring during pregnancy. _____

Full Term: Yes No Birth weight: _____

Delivery: *Normal Breech Cesarean* *Complications:* _____

Was there any evidence of injury at birth? Yes No Explain: _____

Were any of the following experienced before the child's fifth birthday? ___ Ear Infections ___ Convulsions

Other: _____ ___ Serious Accidents ___ Head Injuries

Please give additional information on any item checked above: _____

DEVELOPMENTAL DATA

At what age did the following behaviors first occur?

___ Crawled

___ Sat alone

___ Walked alone

___ Said first words besides "Ma-Ma" and "Da-Da"

___ Speech was clearly understood by others outside the family

___ Toilet trained during day

___ Toilet trained during night

___ Tied shoes

___ Dressed self

___ Slept alone

PHYSICAL CONDITION

My child's general condition is:

- | | |
|-----------------------------------|---|
| Seems to be in good health | Tires easily, listless, lacks energy |
| Overweight | Sleeps too much |
| Underweight | Sleeps too little |
| Overly active; always on the move | Awkward in running, walking, or playing |

List any physical handicaps, serious illnesses, hospital stays, accidents or head injuries (vision, hearing, speech, seizures, operations, diseases, etc. _____

Is your child on any prescription medication? Yes No If so, what? _____

Physician's name: _____

BEHAVIORAL CHECKLIST

(Please check the behaviors that best describe your child)

- | | | |
|--|---|---|
| <input type="checkbox"/> Feels happy with him/herself | <input type="checkbox"/> Sucks his/her thumb | <input type="checkbox"/> Wets the bed |
| <input type="checkbox"/> Demands excessive attention | <input type="checkbox"/> Overly dependent on others | <input type="checkbox"/> Cries often |
| <input type="checkbox"/> Plays well with other students | <input type="checkbox"/> Overly anxious to please | <input type="checkbox"/> Poor self-control |
| <input type="checkbox"/> Exhibits uncooperative attitude | <input type="checkbox"/> Tries to control others | <input type="checkbox"/> Friendly |
| <input type="checkbox"/> Has very few close friends | <input type="checkbox"/> Relates well to adults | <input type="checkbox"/> Sad or depressed often |
| <input type="checkbox"/> Lacks motivation, lazy | <input type="checkbox"/> Aggressive | <input type="checkbox"/> Shy, withdrawn |
| <input type="checkbox"/> Does not adjust readily to change | <input type="checkbox"/> Fearful | <input type="checkbox"/> Daydreams often |
| <input type="checkbox"/> Acts younger than other children | <input type="checkbox"/> Openly affectionate to | <input type="checkbox"/> Easily frustrated |
| <input type="checkbox"/> his/her age | <input type="checkbox"/> family members | <input type="checkbox"/> Jealous of brother(s)sister(s) |
| <input type="checkbox"/> Can be trusted | <input type="checkbox"/> Restless | |
| <input type="checkbox"/> Loud | | |

If you wish to add additional information, please add it below or attach to this form. Thank you for your input.

Parent/Guardian's Signature

Date