ESU 7

Educational Service Unit 7

PARENTS INPUT FORM

Student's Name: _____ Age: _____ Grade: _____

Date of Birth: _____ Parent/Guardian: _____

Date(s) teacher talked to Parent/Guardian regarding this concern: _____

This information will provide valuable input & another viewpoint in creating a successful learning environment for your child.

Academics:

Strengths: _____

_____

Areas of Concern: _____

_____

Speech/Language:

Strengths: _____

_____

Areas of Concern: _____

_____

Behavior/Attention:

Strengths: _____

_____

Areas of Concern: _____

_____

Social Skills:

Strengths: _____

_____

Areas of Concern: _____

_____

Possible motivators – Interests or Hobbies: _____

_____

Have there been any accidents, or concussions? ☐ Yes ☐ No

Explain: _____

Any history of head trauma, brain bleed, oxygen deprivation, high fever, brain infections (meningitis, encephalitis, etc.) ☐ Yes ☐ No

Explain: _____

History of ear infection, tubes, or another hearing related issues ☐ Yes ☐ No

Explain: _____

History of glasses, correction, or other vision related issues ☐ Yes ☐ No

Explain: _____

Have you talked with your physician about any concerns? ☐ Yes ☐ No

Please Explain: _____

Is your child taking medication(s)?

☐ Yes ☐ No

- Name of Physician: _____ Phone: _____

1. Medication: _____ How Often: _____

   Side Effects: _____

2. Medication: _____ How Often: _____

   Side Effects: _____

3. Medication: _____ How Often: _____

   Side Effects: _____

Please return to _____ by _____. Thank You!

Thank you for taking time & sharing this information. If there are any other additional comments you would like your child's school team to be aware of, please indicate those here. _____

_____

SAVE PRINT EMAIL RESET

Modified By: CH
7/21/11