STRATHAM MEMORIAL SCHOOL
39 Gifford Farm Road
Stratham, New Hampshire 03885
(603) 772-5413

Thomas J. Fosher
Principal

J. Rebecca Ruel
Assistant Principal

Patricia M. Gebo
Administrative Assistant

Margaret E. Driscoll
Director of Special Services

Child History

Parent Observation Form

Name of Child _____ Date of birth _____

Parents Names

_____

_____

Addresses

_____

_____

Home Telephone No: _____ Cell No. _____

Occupations

(Father) _____ Work tel# _____ cell phone# _____

(Mother) _____ Work tel# _____ cell phone# _____

Child's Family Includes:

Brothers (names and ages) Sisters (names and ages)

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

Who does the child live with? _____

Are there others who live in the home? _____

Please answer the questions on this form in the best way that you can. You will be able to answer some quite easily and you may have difficulty in making a decision on others.

Your answers on this form will help the school staff and will involve you in deciding with the principal what kind of educational environment is best suited for your child's abilities and style.

Chronic Health Concerns:

____ Asthma

____ Diabetes

____ Allergies: (please list)

Foods _____

Environmental _____

Medications _____

Please list all daily medications: _____

_____

Hospitalizations (please give dates and explanation) _____

_____

____ urinary problems

____ bowel problems

____ other

Dietary Habits:

Dietary restrictions: _____

Eats well balanced meals: Yes____ No ____

Birth History

Length of pregnancy _____ Birth weight _____ Apgar score _____

Describe any illnesses during pregnancy (ex. Diabetes, toxemia, hypoglycemia)

_____

Was medication used during pregnancy? _____

Did any of the following occur during the birth process?

____ Premature ____ Transfusion ____ Caesarian section

____ Breech birth ____ Prolonged labor ____ Oxygen problems

____ Blood incompatibility (RF factor) ____ Fetal distress

Were there any difficulties with the baby after birth? _____

Have any siblings died? _____ If so, what was the cause? _____

General Health History

Please check any health concerns that you have regarding your child:

____ breathing difficulty

____ frequent stomach aches

____ frequent fevers

____ constipation

____ nosebleeds

____ serious head trauma

____ sleeping difficulties

____ nail biting

____ fainting

____ considered hyperactive

____ ear infections

____ sinus infections

____ bed wetting

____ headaches

____ thumb sucking

____ other (please explain)

Language Development

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

First words _____ Two or three words together _____

Sentences _____

Does your child:

1.	Stuttering?	Yes	No
2.	Have difficulty expressing ideas and concepts?	Yes	No
3.	Have articulation errors?	Yes	No

Visual Assessment

Has your child ever had a vision examination or treatment? Yes No

When? _____ By whom? _____

Results _____

Hearing Assessment

Has your child ever had any ear/hearing examination or treatment? Yes No

When? _____ By whom? _____

Results _____

Is your child bothered by loud noises? Yes No

Motor Development

This child began walking at age (if approximate, label as such) Age _____

Does your child:

1. Catch/throw balls? Yes No
2. Enjoy physical activities? Yes No
3. Lose balance, trip, fall more often than "usual" Yes No
4. Have difficulty running? Yes No
5. Hop on one foot, gallop and skip (1st grade +) Yes No
6. Use playground equipment safely? Yes No
7. Ride a tricycle/bicycle? Yes No

Do you feel that your child has adequate fine motor skills? Yes No

1. Can they color inside the lines? Yes No
2. Can they use scissors adequately? Yes No
3. Can they button and zipper? Yes No

Social Development

Does your child:

1. Have regular playmates the same age?	Yes	No
2. Have difficulty getting along with other children	Yes	No
3. Become easily frustrated?	Yes	No
4. Cry often?	Yes	No
5. Have a bad temper?	Yes	No
6. Enjoy cooperating with others?	Yes	No
7. Become frequently irritated or moody?	Yes	No
8. Become upset by changes in routine?	Yes	No
9. Frequently seeks individual adult attention?	Yes	No
10. Accept discipline and limits?	Yes	No
11. Prefers to be the organizer with peers?	Yes	No
12. Sensitive to certain smells, tastes, sounds, texture?	Yes	No

How many hours of screen time/day _____

How many hours of outdoor free play/day _____

How many hours of organized play/day _____

Toileting:

At what age was your child toilet trained? Urinary _____

Bowels _____

Is your child independent with toileting hygiene (wiping self, washing hands) Yes No

Preschool/Childcare Experience:

Has the child attended a preschool? Yes No # of yrs. ____

Has your child attended a childcare program? Yes No # of yrs. ____

Has your child been involved in group activities (story time at library, playgroups, etc.)

Yes No

Does your child enjoy books/being read to? Yes No

Other:

Would you like an individual conference with the school nurse or guidance counselor to relay and information you do not feel you can include on this form? _____

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

_____

_____

Thank you for your patience in filling out this questionnaire.