

Aiken County Public Schools

Demographic, Medical, Developmental, and Educational History

NOTE: If you need assistance completing this form, please contact your child's school or call 803-641-2621.

Child's Full Name _____ Nickname _____ Date of Birth _____
Race (check only one): ___ Hispanic/Latino of any and all races ___ White ___ Black ___ Asian ___ American Indian or Alaska Native ___ Native Hawaiian or Other Pacific Islander ___ Two or more races but not Hispanic/Latino
Current School _____ Other Schools Attended _____
Grade _____ Grades Repeated _____ SS# _____ Medicaid # _____
Mailing Address _____ Street _____
Phone Numbers _____
Email Address _____

DEMOGRAPHIC

MOTHER / FEMALE GUARDIAN IN HOME

Name _____
Relationship to Child _____
Age _____ Marital Status _____
Level of Education Completed _____
Occupation _____
Employer _____

FATHER / MALE GUARDIAN IN HOME

Name _____
Relationship to Child _____
Age _____ Marital Status _____
Level of Education Completed _____
Occupation _____
Employer _____

LIST PARENTS NOT LIVING IN THE HOME

Name	Relationship	Contact/Involvement with Child
_____	_____	_____
_____	_____	_____

NAME OF PARENT(S) WHO HAS LEGAL CUSTODY _____

LIST BROTHERS AND SISTERS OF CHILD (Attach additional page if necessary.)

Name	Age	Sex	Living in home?	
_____	_____	_____	Yes	No
_____	_____	_____	Yes	No
_____	_____	_____	Yes	No
_____	_____	_____	Yes	No

LIST OTHER PERSONS WHO ARE CURRENTLY LIVING IN THE HOME NOT NAMED ABOVE

Name	Age	Sex	Relationship
_____	_____	_____	_____
_____	_____	_____	_____

Have any of the child's biological parents, grandparents, and / or siblings ever received special education services?
() Yes () No If yes, please explain. _____

What is the primary language spoken in the home? ___ English Other _____

What is the student's primary language? ___ English Other _____

Describe any cultural factors which might affect your child's social and/or academic functioning. _____

How does your child get along with others at home? _____

Has your child ever had previous psychological or educational evaluations? By whom? _____

Has your child ever been involved with any outside agencies such as Mental Health, DJJ, or DDSN? If yes, please list.

MEDICAL

Did the mother receive prenatal care from a physician? () Yes () No

Did the mother experience any of the following during pregnancy or delivery?

- | | | |
|---|---|--|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Excessive vomiting | <input type="checkbox"/> Use of illicit drugs (marijuana, cocaine, etc.) |
| <input type="checkbox"/> Toxemia | <input type="checkbox"/> Physical injury | _____ |
| <input type="checkbox"/> RH incompatibility | <input type="checkbox"/> Use of forceps during delivery | <input type="checkbox"/> Prescribed medication _____ |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Illness | |
| <input type="checkbox"/> Gestational diabetes | <input type="checkbox"/> Use of tobacco products | Other _____ |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Use of alcohol | _____ |

Was the baby born prematurely? () Yes () No If yes, how many weeks premature? _____

What was the baby's weight at birth? _____ pounds _____ ounces

Did the baby experience any complications at birth?

- | | |
|--|---|
| <input type="checkbox"/> Lengthy hospital stay | <input type="checkbox"/> Heart problems |
| <input type="checkbox"/> Physical defects | <input type="checkbox"/> Use of incubator |
| <input type="checkbox"/> Breathing problems | <input type="checkbox"/> Use of forceps during delivery |
| <input type="checkbox"/> Oxygen deprivation | <input type="checkbox"/> Other _____ |

List any prescription medications which your child is currently taking.

<i>Name of Medication</i>	<i>Dosage</i>	<i>Purpose</i>
_____	_____	_____
_____	_____	_____
_____	_____	_____

What is the name and city of your child's physician? _____

Please check all that apply to your child. For those checked, **please provide the date or age at which it occurred or began.**

- | | |
|---|---|
| <input type="checkbox"/> Head injury _____ | <input type="checkbox"/> Tuberculosis _____ |
| <input type="checkbox"/> Seizures _____ | <input type="checkbox"/> Fever of 104 or higher _____ |
| <input type="checkbox"/> Coma _____ | <input type="checkbox"/> Frequent ear infections _____ |
| <input type="checkbox"/> Stroke _____ | <input type="checkbox"/> Allergies _____ |
| <input type="checkbox"/> Cerebral palsy _____ | <input type="checkbox"/> Hearing problems _____ |
| <input type="checkbox"/> Meningitis _____ | <input type="checkbox"/> Vision problems _____ |
| <input type="checkbox"/> Encephalitis _____ | <input type="checkbox"/> Asthma / Respiratory problems _____ |
| <input type="checkbox"/> Brain tumor _____ | <input type="checkbox"/> Heart problems _____ |
| <input type="checkbox"/> Shaken Baby Syndrome _____ | <input type="checkbox"/> Digestive problems _____ |
| <input type="checkbox"/> Migraine _____ | <input type="checkbox"/> Rheumatic Fever _____ |
| <input type="checkbox"/> Fetal Alcohol Syndrome _____ | <input type="checkbox"/> Measles _____ |
| <input type="checkbox"/> Lead poisoning _____ | <input type="checkbox"/> Complications from chicken pox _____ |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Emotional/Behavioral problems _____ |
| <input type="checkbox"/> Cystic Fibrosis _____ | <input type="checkbox"/> Other _____ |

How would you describe your child's present health? () Poor () Fair () Good () Excellent

Typically, how many hours per night does your child sleep? _____

Does your child have any sleep problems or disorders (exs. sleep apnea, night terrors, sleep walking, difficulty going to or staying asleep)? _____

DEVELOPMENTAL

Place a check beside any area in which your child had significant difficulty as an infant and/or toddler.

- Feeding Motor skills Weight / Failure to thrive Excessive crying
- Separating from parents Temper tantrums Being held / affection

At approximately what age did your child develop the following skills? Please circle the age range.

Rolling over	Less than 5 months	5 to 7 months	7+ months
Crawling	Less than 7 months	7 to 12 months	12+ months
Sitting unassisted	Less than 12 months	12 to 24 months	24+ months
Walking unassisted	Less than 18 months	18 to 24 months	24+ months
Toilet trained during day	Less than 24 months	24 to 30 months	30+ months
Toilet trained day and night	Less than 24 months	24 to 36 months	36+ months

LANGUAGE DEVELOPMENT

1. At what age did your child say his/her first words? _____ Put words together? _____
2. What were your child's first words? _____
3. Does your child appear to hear well? () Yes () No _____
4. Does your child follow directions given orally? () Yes () No _____
5. Do you think your child has a speech or language problem? () Yes () No _____
6. Does your child appear to be aware of any differences in his/her speech? () Yes () No If yes, how does he/she react?

7. Has your child ever been evaluated by or received speech-language therapy from any agency or individual? () Yes () No
If yes, by whom? _____
8. Are there any known conditions affecting his/her tongue, palate, nose, throat, vocal cords, or ears (i.e. cleft palate, vocal nodules, etc.?) () Yes () No _____

EDUCATIONAL

Does or did your child attend preschool or daycare? () Yes () No

When your child has an academic problem at school, how do you deal with it at home? _____

How do you reward and reinforce appropriate behaviors in your child? _____

How do you punish inappropriate behaviors in your child? _____

How would you describe the student's ability to learn? () Average () Above average () Slower than children of same age

How would you describe the student's effort to learn? () Average () Great deal of effort () Very little effort

When did you first become concerned about your child's learning and/or behavior? _____

What are your child's strengths? _____

What are your child's weaknesses? _____

The information you have reported on this form may be used to plan and conduct an evaluation of your child. Is there any other information which you feel should be considered? _____

Completed By _____ Date _____

Updates

Date _____ Information obtained by _____ From _____

Demographic _____

Medical _____

Developmental _____

Educational _____

Date _____ Information obtained by _____ From _____

Demographic _____

Medical _____

Developmental _____

Educational _____

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Demographic _____

Medical _____

Developmental _____

Educational _____

Date _____ Information obtained by _____ From _____

Demographic _____

Medical _____

Developmental _____

Educational _____