History & Home Life

2019-2020 School Year – 1 per child

Child's Name: ______________________________ **Date of Birth:** ______________

Having the most up to date information about your child's history and home life helps Wingra to better know your child, which, in turn, helps us to meet your child's needs, in partnership with you.

General Health: ____

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Vision History

Date of last eye exam: ______________ By whom? ______________________ Glasses? __________

Other eye problems (i.e. injury or surgery)? ____

Hearing History

Date of last hearing exam: ______________ By whom? ______________________

Ear tubes? ____________ If yes, when were they inserted? ____________ Are tubes still in place? __________

Other Significant Medical History

Any major illnesses, accidents, prolonged medication, prolonged health issues? ___________________________

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Allergies (please list): ____

____

Has your child had chicken pox? Yes No

Home Life Routines

Approximate bedtime: __________ Approximate number of hours of screen time per day: ____________

Please comment on your child's relationship with parents, siblings, and others in the household: ________________

____

____

Generally speaking, what are your child's responsibilities in the home? ____________________________

____

How does your child manage transitions, such as bedtime, mealtime, cleanup, end of screen time? ______________

____

(Information continued on reverse) →

Other Information

Does your child have any special classroom needs or things we might keep in mind? ______________________________

____

Has your child experienced social, emotional, or physical challenges that may affect adjustment to school?

____

____

Is there any significant family history about which we should know (i.e. diabetes, seizures, heart conditions, significant allergies)?

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Has your child had a special education evaluation by a private evaluator or by a school district? Yes No

If yes, when was the evaluation completed? ___________________________

Who competed the evaluation? ______________________________________

If completed by a school district, was your child found eligible for:

An Individualized Education Program/Plan (IEP)? Yes No
A 504 Plan? Yes No

Has your child had a referral to or received any of the following services? Yes No
If yes, please circle all that apply:

Occupational Therapy (OT) Physical Therapy (PT)

Speech Language Pathology (SLP) Sensory Integration Therapy

Academic tutoring (please specify): ____

Other (please specify): ____

Parent/Guardian Signature ____ ***Date:*** _______________