ROCKVILLE CENTRE UNION FREE SCHOOL DISTRICT

SCHOOL ENTRANT APPRAISAL FORM

HEALTH -- HOME FAMILY DATA

Today's Date: _____

Student's Name: _____ Date of Birth: _____

Address: _____ Place of Birth: _____

_____ Telephone Number: _____

School: _____ Grade: ____ Teacher: _____

Father's Name: _____ Phone: _____

Father's Address (if different from above): _____

Check One: Natural: ____ Foster Parent: ____ Guardian: ____ Adopted: ____

Father's Place of Birth (Country): _____ Education: _____

Mother's Name: _____ Phone: _____

Mother's Address (if different from above): _____

Check One: Natural: ____ Foster Parent: ____ Guardian: ____ Adopted: ____

Mother's Place of Birth (Country): _____ Education: _____

Do both parents live in the home? Yes____ No ____ Divorced ____ Separated ____

Did this child attend a nursery or preschool? Yes____ No ____ If yes, where _____

Did this child repeat any grade level? Yes ____ No ____ If yes, what grade was repeated? _____

Language(s) spoken in the home (other than English) _____

Other Children Living at Home:

Name _____ Age ____ Name _____ Age ____

Name _____ Age ____ Name _____ Age ____

Name _____ Age ____ Name _____ Age ____

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HEALTH HISTORY

Student's Name: _____ Date of Birth: _____

PRENATAL HISTORY (Mother)

While pregnant with this child, were you under a doctor's care? Yes____ No____

During this pregnancy, did you have:	Yes	No	When	Describe
Anemia				
Elevated Blood Pressure				
Toxemia				
Swollen Ankles				
Kidney Disease				
Heart Disease				
Diabetes				
Bleeding				
Measles				
German Measles				
Flu				
Other Virus				
Other Illness				
Vomiting				
Injury				
Medication During Pregnancy				
Emotional Problems				
Threatened Miscarriage or Early Contractions				

BIRTH

Was the delivery unusual in any way? Yes ____ No ____ If yes, please explain.

_____

NEONATAL HISTORY

	Yes	No	Don't Know
Is this baby a twin?			
If a twin, was this baby born first?			
Did the baby have breathing problems?			
Did the baby have the cord around its neck?			
Did the baby cry quickly?			
Was the baby's color normal?			

NEONATAL HISTORY (CONTINUED)	Yes	No	Don't Know
If this baby's color wasn't normal, was the baby's color blue?			
Was oxygen used for the baby?			
If oxygen was used, how long?			
Was the baby premature?			
If the baby was premature, how much?			
What did the baby weigh?			
During the hospital stay, did your baby have Yellow Jaundice?*			
Rash?*			
Convulsions?*			
Excessive Crying?*			
If yes to above, please describe.*			
Did you take the baby home with you from the hospital? If answer is no, how long after you did the baby come home?			
Did you have any problems with feeding?			
If there were problems with feeding, please describe.			
Was the baby normally active?			
If the baby wasn't normally active, please describe.			

DEVELOPMENTAL HISTORY

	Yes	No	Don't Know
Does your child have problems with eating?			
Does he/she have problems with sleeping?			
Can he/she use a spoon and fork to eat without spilling a lot?			
Can your child wash and dry his/her own hands?			
Can he/she dress himself/herself?			
Can he/she do buttons?			
Can he/she be left alone with a baby-sitter without a big fuss?			
Does your child play successfully with puzzles, blocks and other toys without help?			
Can he/she hold a pencil properly?			
Can he/she write and draw rather than scribble?			
Does he/she prefer right hand?			
Does he/she prefer left?			
Does child prefer both hands?			
Can your child ride a tricycle?			
Can he/she throw and catch a ball?			
Does your child have many accidents?			

DEVELOPMENTAL HISTORY (CONTINUED)	Yes	No	Don't Know
Does your child drop things more often than other children that are the same age?			
Does your child trip easily?			
Does your child run into things?			
Does your child have any trouble climbing stairs?			
Is your child highly active?			
Is your child very quiet?			
Is your child generally a happy child?			
Does your child cry easily?			
Does your child have temper tantrums?			
Does your child hold his/her breath?			
Does your child usually follow directions?			
Does he/she have a short attention span?			
Is your child able to say most sounds correctly?			
Is your child understandable to a stranger?			
Is he/she afraid to speak?			
Did your child speak later than other children you know?			
Does your child often repeat sounds or words (stutter or stammer)?			
Has your child received or is receiving speech/language therapy? If yes, where? _____ If yes, how often?			
Does your child omit words or mix up the word order of a sentence? Example: I see boy. I want go to home.			

HEARING AND VISION

	Yes	No
Has your child ever had trouble seeing?		
Have your child's eyes ever looked crossed?		
Has your child had frequent ear infections?		
Does your child turn on the television at a very high volume?		
Does your child say, "What, what?" all the time?		
Does he/she sit very closely to the television screen?		
Does your child bend over and look very closely at pictures or drawings?		
Has your child had any screening procedures or evaluations?		
If yes, please give date and Results:		

Please use the back of this form if there is anything further you wish to mention regarding your child.