School Evaluation Form

I. STATISTICS

1. Childs Full Name:_____
2. Sponsors last 4:_____
3. Date of Birth:_____
4. Father's Name:_____
5. Mother's Maiden Name:_____
6. Family Members in your school:

	NAME	AGE	GRADE
a.			
b.			
c.			
d.			

7. Present Home Address:_____
8. Home Telephone Number:_____
9. Emergency Number:_____

II. SCHOOL INFORMATION

1. Name of School:

_____Address:_____

_____Phone Number:_____

2. Principal:_____
3. Date of Child's Enrollment:_____
4. Present Grade:_____
5. Number of pupils in class:_____
6. Type of class (circle one) ACCELERATED NORMAL SPECIAL OTHER

Comments:_____

School Evaluation Form (continued)

7. Length of School Day:_____hours.

8. How much time is allotted to do the following activities;

	Morning	Afternoon
a. Recess	_____	_____
b. Instruction	_____	_____
c. Play	_____	_____
d. Gym	_____	_____
e. Lunch	_____	_____

9. Concerning lunch break is the child (check one):

( ) "captive" –must stay in the lunchroom all period

( ) "free" –permitted to play and talk after lunch

( ) goes home for lunch

10. Attendance:

a. Current Year: Days absent:_____Days Late:_____Medical excuses:_____

b. Previous Year: Days absent:_____Date Late:_____Medical excuses_____

11. Grading system (circle one):

a. Numerical b. Letter c. Satisfactory-Unsatisfactory d. Other

12. Previous Schools Attended:

a. Name:_____

b. Location:_____

c. Grade Level Attained:_____

d. Comments on performance, reason for repeated grade(s):_____

_____

School Evaluation Form (continued)

III. PHYSICAL HEALTH REPORT:

1. Mention any pertinent medical history known to the school: current significant illnesses, medications being taken while in school, or incapacitations._____

2. School doctor and/or nurse comment:_____

3. Date of last complete physical examination and abnormal findings:_____

4. Can and does the child fully participate in classroom activities, gym, and organized athletics:_____

5. Any history of seizures, mental lapses, excessive staring spells, unusual repetitive actions, heart, lung or urinary problems, grave illnesses?_____

IV. CURRENT SCHOOL PROGRESS:

1. How well does this child function in the school setting?_____

2. Specific achievements in basic academic skills: (check appropriate boxes)

   a. Reading ( )_____

   b. Spelling ( )_____

   c. Arithmetic ( )_____

   d. Penmanship ( )_____

   e. Oral Expression ( )_____

   f. Art ( )_____

   g. Shop ( )_____

   h. Other ( )_____

Special Interest and talents noted in school:_____

General Comments:_____

School Evaluation Form (continued)

_____

3. Does the child have the manual dexterity to manipulate classroom materials easily? (Consider the use of Crayons, blocks, pens, shope tools, gym equipment, etc.)_____

_____

_____

4. Does the child understand spoken language adequate for his age group? (Consider oral instructions and Explanations, class discussion, general responses)_____

_____

_____

5. Does he/she have an adequate fund of age-appropriate general information?_____

_____

6. Does he/she remember and utilize when he/she learns?_____
   a. Immediate recall:_____
   b. Long-term memory:_____
7. Does the pupil comprehend abstract concepts? (Ex: time, hate, love)_____

_____

8. Does the child demonstrate any visual or hearing problems?_____

_____

9. Does the child have homework, is it done, and to what degree of proficiency?_____

_____

10. Is his/her overall school performance reasonably consistent?_____

_____

V. INTERPERSONAL RELATIONSHIPS:

1. How does the child relate to you and other adults?_____

_____

2. How does he/she relate to his/her peer group in school and on the playground?_____

_____

_____

School Evaluation Form (continued)

3. How does the child relate to much younger and much older children?_____

_____

_____

VI. REASON FOR REFERRAL:

1. List the main questions and/or areas of concern the school would like answered through medical evaluation of this child._____

_____

_____

_____

VII. ANCILLARY SERVICES:

1. Does your school have a Guidance and/or Psychology Department? (Name, position, and phone Number of responsible persons)_____

_____

_____

2. If any previous psychometric testing an/or counseling have been completed, please summarize giving agency which administered it and date._____

_____

_____

3. What steps have been taken and/or what recommendations have been made to assist the child in "problem" areas? Specifically mention other referrals, agencies utilized, special classes, extraordinary School assistance and results of these endeavors._____

_____

_____

4. What other program or services are available in your school that you think would be of help to this child? Can these be made available?_____

_____

_____

School Evaluation Form (continued)

Thank you for your patience and cooperation in completing this questionnaire. We sincerely hope that we can be of assistance to you.

_____	_____	
_____	_____	
_____	_____	
Signature(s) of person(s) completing form	Title/Position	Date

I authorize the release of the above information and the results of any testing done on behalf of my son/daughter to Dr._____.

_____

SIGNATURE OF PARENT/GUARDIAN