WILLARD R-II SCHOOLS SPECIAL EDUCATION
407 FARMER ROAD WILLARD, MO 65781
PHONE 417-742-0930 FAX 417-742-0841

FAMILY-HEALTH-DEVELOPMENTAL HISTORY
PARENT INPUT/CONTACT FORM

For summary of existing data for Initial Evaluation

Dear Parent/Guardian,

Your child has been referred for an evaluation by either district staff or yourself. Your input is needed in order to complete this evaluation. Please include any information that would be helpful to us in understanding your child. Please complete the following information and return it to the school as soon as possible. Also, please provide copies of any reports or evaluations from other sources that may be relevant to the review.

STUDENT INFORMATION:

Last Name:_____ First Name:_____ Middle Initial:_____

Address:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Sex:_____ Race (circle one): Blk Wh Asian NativeAmer/Eskimo Hisp DOB:_____ Age:_____ Grade:_____

Email: _____ Social Security#:_____-_____-_____ Medicaid #:_____

(Office Use Only: Teacher:_____ Attending School:_____ Neighborhood School:_____

Name of Parent / Legal Guardian:_____

Is student living with legal guardian? ____Yes ____No If No, please state address of the student's legal guardian:

_____

FAMILY INFORMATION:

	Name	Employment	Check if living with student
Mother	_____	_____	____
Stepmother	_____	_____	____
Father	_____	_____	____
Stepfather	_____	_____	____

Other Children in the Family:

Child's Name	Age	Grade	Relation to Student	Check if living at home	Educational Problems	Health Problems

Primary Language Spoken in the Home:_____ Secondary Language Spoken in Home:_____

If primary language is not spoken English, is an interpreter needed? Yes No

STUDENT'S HEALTH HISTORY: (Use reverse side to describe any health conditions or hospitalizations your child has experienced beyond the typical illness of childhood.)

Was birth Premature?_____ Describe any difficulties during pregnancy and birth _____

_____

Describe any major illnesses, injuries, or operations. Include incidence of seizures or extremely high temperatures.

_____

Is your child frequently troubled by any of the following: ____Colds ____Earache ____Sore Throat ____Other:_____

Last Physical examination: Date_____ Physician_____ Results_____

Last Dental examination: Date_____ Dentist _____ Results_____

DEVELOPMENTAL HISTORY:

Age your child: Sat alone_____ Crawled_____ Walked alone_____ Fed self_____

Said first word_____ Said two-word sentence_____ Toilet trained_____

Has your child received health services from an agency such as (please check any/all that apply):

___Children's Miracle Network ___Division of Family Services ___Big Brothers/Sisters ___First Steps ___Other

Please check if your child has been seen professionally outside of the school for any of the following and list the service provider(s) (i.e., Regional Center, Division of Family Services, etc.).

_____Speech Therapy _____

_____Language Therapy _____

_____Physical Therapy _____

_____Occupational Therapy _____

_____Private Tutoring _____

_____Counseling _____

_____Other – describe: _____

CURRENT MEDICAL/HEALTH STATUS:

Does your child have any of the following:

YES	NO		Medication (if prescribed)
_____	_____	Seizure Disorder: Petit Mal Grand Mal Dr._____	_____
_____	_____	Allergies: Asthma, Hay Fever, Food, Immunizations, Drugs, Insect Stings	_____
_____	_____	Cerebral Palsy: Spastic Athetoid Mixes Hemiparesis Paraparesis Quadreparesis Mild Moderate Severe	_____
_____	_____	Cleft Palate: Surgically Repaired	_____
_____	_____	Tongue Tied (Ankyloglossia): Surgically Repaired /Not Repaired	_____
_____	_____	Circle: Heart Disease Diabetes Kidney Disease Arthritis Cancer Hemophilia Muscular Dystrophy Scoliosis Cystic Fibrosis	_____
_____	_____	ADD ADHD: Describe_____	_____
_____	_____	Special Procedures: Describe_____	_____
_____	_____	Dietary Concerns: Describe_____	_____
_____	_____	Other: Describe_____	_____

STUDENT'S EDUCATIONAL HISTORY:

Did your child participate in Parents As Teachers?_____Yes _____No Early Childhood Special Education? _____Yes _____No

Preschools and/or daycares attended and date of attendance:

_____

_____

CURRENT CONDITIONS, DEVELOPMENTAL AND PARENTAL CONCERNS:

AREA	PLEASE TELL US ABOUT YOUR CHILD IN EACH AREA
GENERAL HEALTH *(Describe current health status. Past, Current, or Chronic diagnoses – include date of diagnosis and doctor's name)*	
GROSS MOTOR SKILLS *(sitting, walking, running, climbing stairs, skipping, catching/throwing, kicking, biking, etc.)*	
FINE MOTOR SKILLS *(scribbling, writing, coloring, cutting, fasteners, tying shoes)*	
VISION *(Has child's vision been screened? Results? Specify if student wears glasses)*	
HEARING *(Has your child's hearing been tested? By whom? Results? Frequent ear infections? Family history of hearing problems?)*	
COMMUNICATION – SPEECH *(How well do you understand your child? Do strangers easily understand him/her? Specific concerns? Does your child suck his/her thumb fingers or use a pacifier?)*	
COMMUNICATION – LANGUAGE *(Does your child understand and follow directions? Is he/she learning new vocabulary at a steady rate? Is he/she able to tell name, age, boy/girl? Does he/she use ords or sentences to ask for things, ask questions, and comment on things? Give an example of sentences your child might use.)*	
SOCIAL/EMOTIONAL *(How does your child interact with family members, siblings, other children, teachers, other adults? Can take turns? Helps others? Will separate from parent? General temperament?)*	
GENERAL INTELLIGENCE *(Does your child show an interest in and ability to learn new things quickly? Can he/she imitate others? What kinds of activities/toys/puzzles does your child enjoy? Does he/she enjoy playing cooperatively with others? Adequate attention span?)*	
ADAPTIVE BEHAVIOR *(Describe dressing (on and off), eating (finger/spoon/fork/knife, food likes and dislikes) and drinking (bottle/sippy cup / cup, likes and dislikes), grooming (bathing, combing hair, brushing teeth), and toileting skills.*	
ACADEMIC / TRANSITION *(How does your child show an interest in books Can he/she identify some colors, numbers, shapes, letters, words, sing familiar songs, count? Can he/she match, sort, categorize? Transition from one activity to another?)*	

ASSISTIVE TECHNOLOGY *(Does your child use or need assistive technology or adaptive equipment in order to care of his/her own needs or to interact with others?)*	
OTHER *(Please provide any additional information you would like to share)*	

Person completing form: _____ Date: _____

Relationship to student: _____Biological Mother _____Stepmother _____Adoptive _____Grandparent(s)

_____Biological Father _____Stepfather _____Foster _____Other (specify)

ECSE

Dear Parents,

For our data collecting requirements, we need to establish the amount of time per week that your child is in an educational environment. Please assist us by completing the following information.

Childs name_____

1. Outside of the Willard's ECSE program does your child attend another preschool/daycare/childcare program ? Yes / No

2. If yes, please give the name of the program _____

3. Number of hours per week (Monday-Friday) that your child attends this program._____

_____

Parent Signature

Thank You for your help!

ESY Eligibility Guide

Name _____

IEP Date_____

						Total
Regression/Recoupment	3	6	9	12	15	____
Nature and severity of disability	3	6	9	12	15	____
Areas of learning crucial to the attainment of self-sufficiency and independence	3	6	9	12	15	____
Critical period for attainment of a skill	2	4	6	8	10	____
Child's progress on IEP goals	2	4	6	8	10	____
Behavioral needs	1	2	3	4	5	____
Physical needs to include any therapies	1	2	3	4	5	____
Opportunities to practice outside classroom setting and availability of alternative resources	1	2	3	4	5	____
Areas of curriculum which need continuous attention	2	4	6	8	10	____
Child's vocational needs (pre-vocational/ pre-academic)	1	2	3	4	5	____
Ability of childs' care givers to provide structure at home and opportunity to interact with nondisabled peers	1	2	3	4	5	____

Total points ____

**Each student will be individually considered as a candidate for ESY by the IEP team. Students with Scores of 60 and above will be given greater consideration. Students will be staffed in April each year for ESY eligibility, if at last IEP meeting it was determined that additional information was needed before ESY decision could be made. Otherwise, the ESY decision will be made at the annual IEP meeting.

**Staple to draft IEP and put in protocol file.

Missouri Outcomes Summary Sheet (MOSS)

Entry: _____ Exit: _____
Date Date

Child Information:

Name: _____
Last First Middle Initial

Date of Birth: _____

MOSIS ID/ECSE: _____

Child ID/First Steps: _____

District/SPOE Name: _____

Persons involved in deciding the summary ratings:

Name	Role

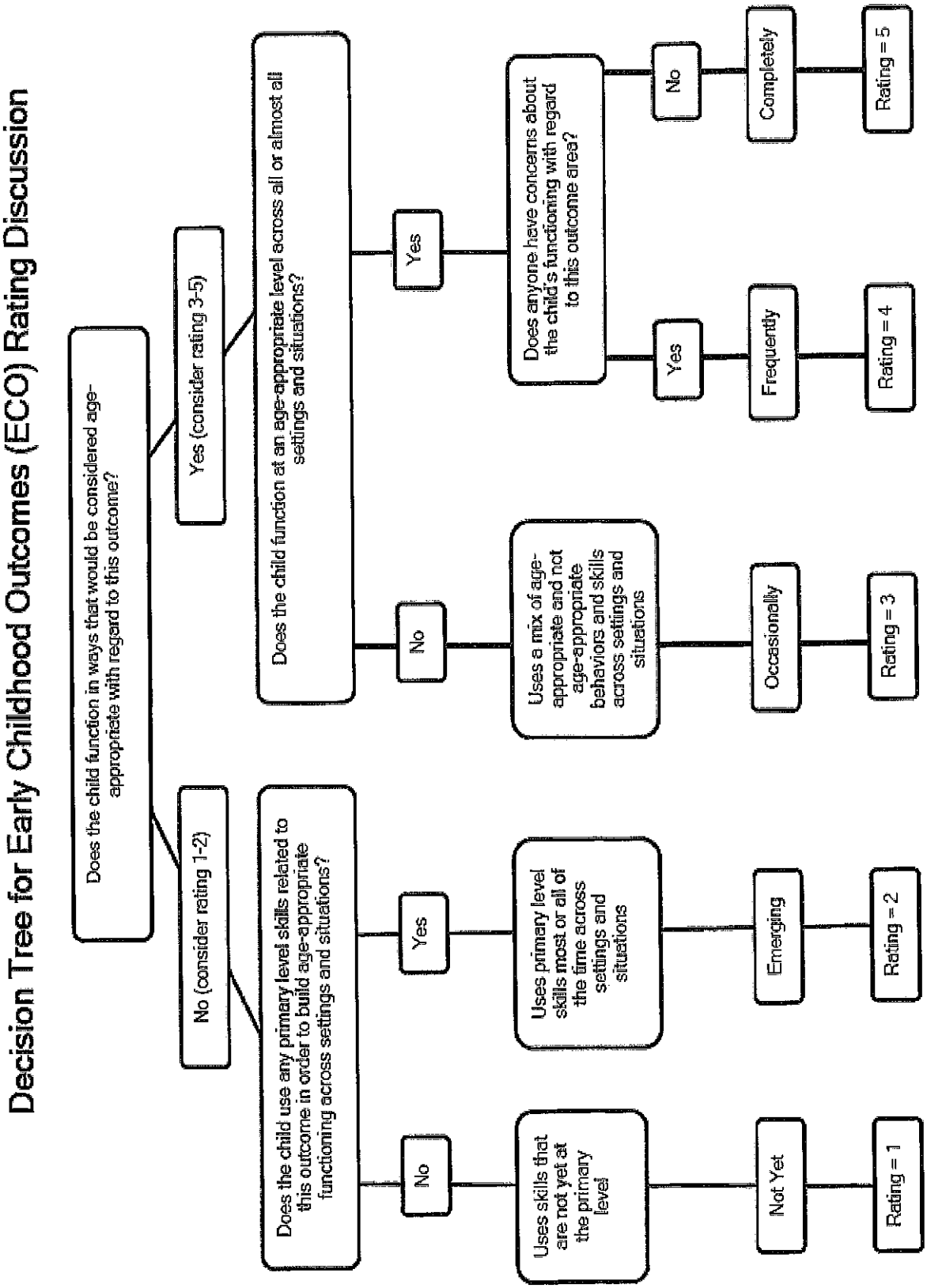
Information on child functioning (check all that apply):

___ Review of existing data
___ Assessment results
___ Parent input
___ Professional observation

Record final rating:

OSEP Indicator	Entry Rating	Exit Rating
1. Positive Social-Emotional Skills		
2. Acquiring and Using Knowledge and Skills		
3. Taking Appropriate Action to Meet Needs		

1. Positive Social-Emotional Skills *(Entry marked in red, Exit marked in blue)*



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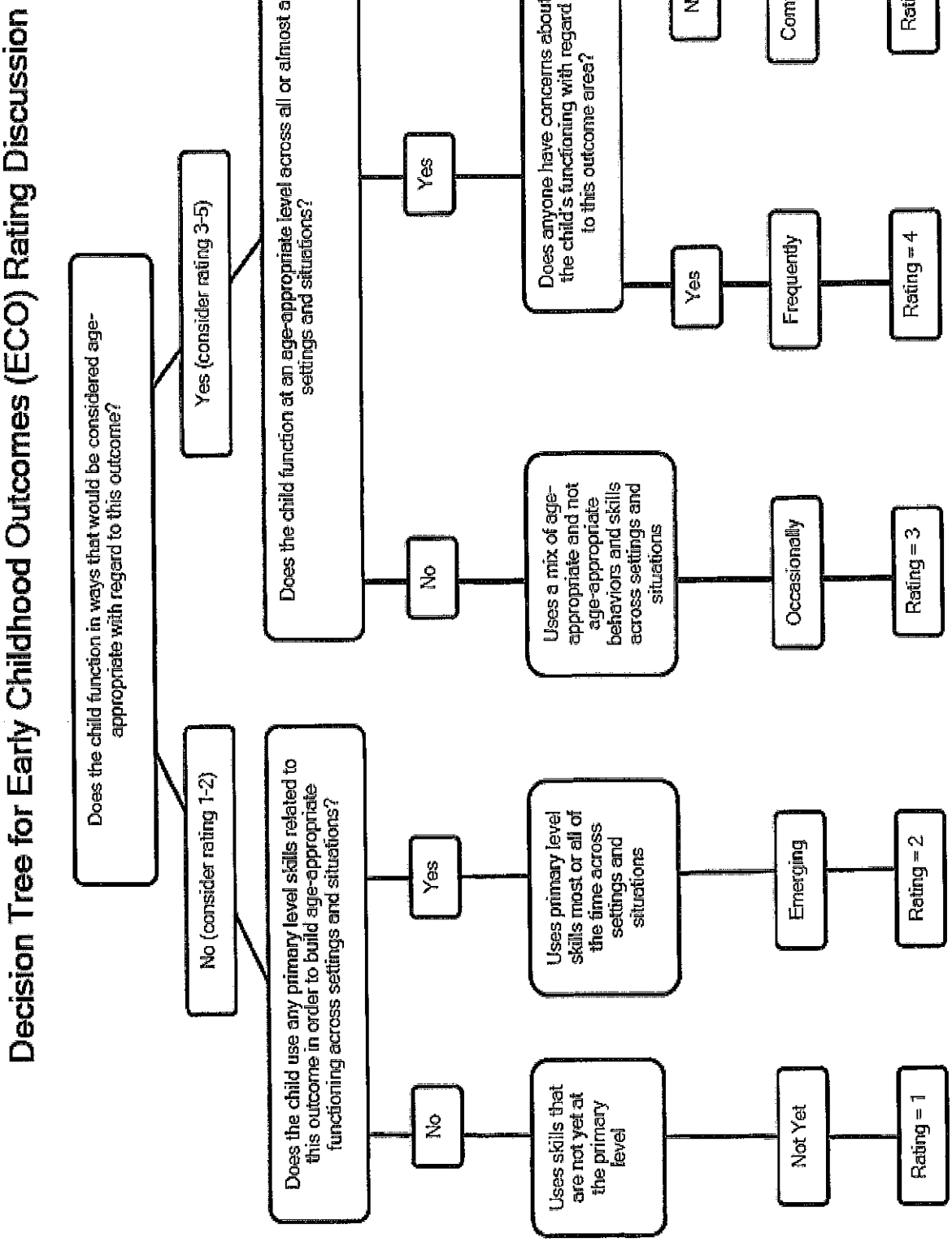
2. Acquiring and Using Knowledge and Skills *(Entry marked in red, Exit marked in blue)*



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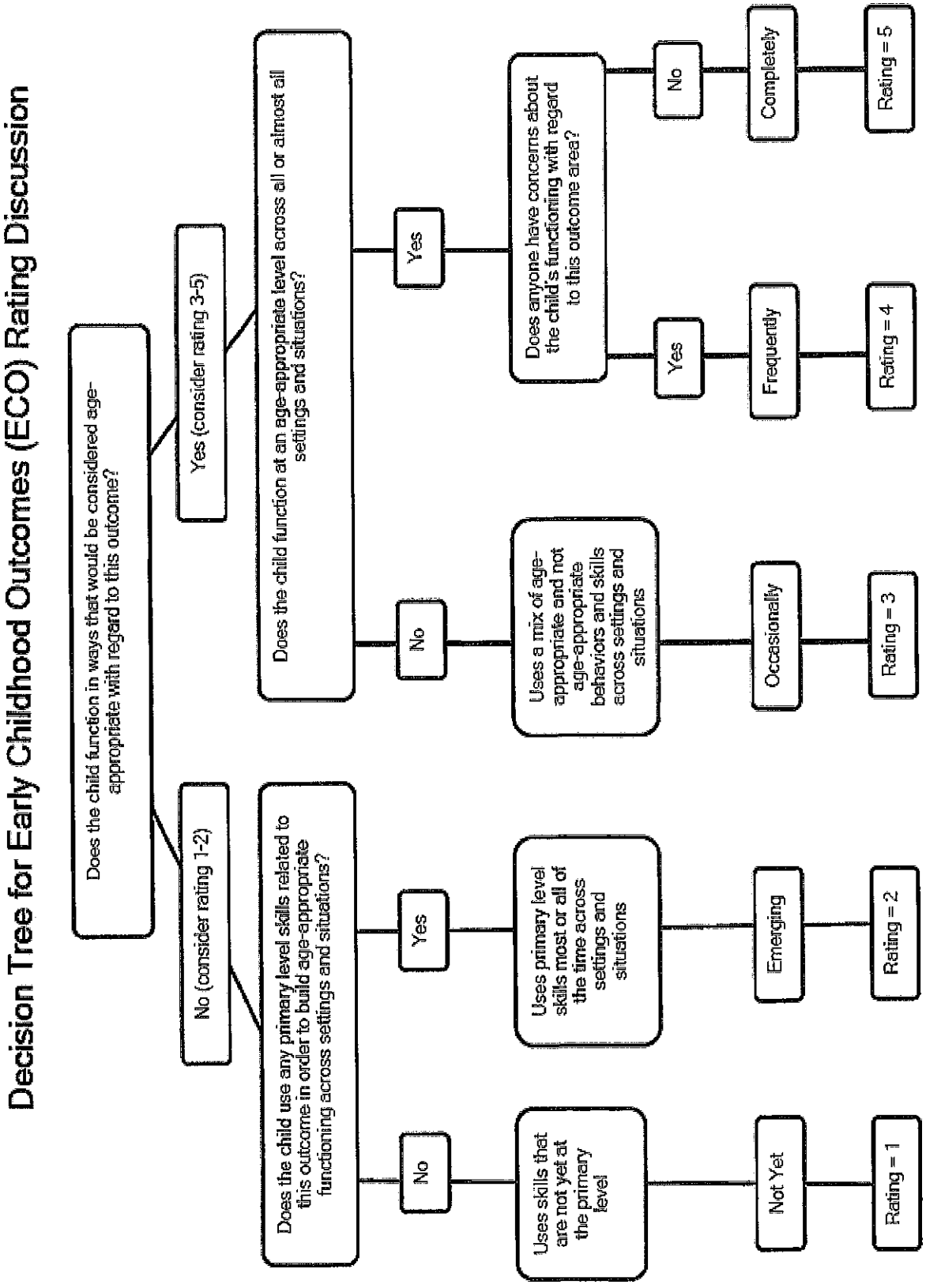
3. Taking Appropriate Action to Meet Needs *(Entry marked in red, Exit marked in blue)*



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