

Most Blessed Sacrament  
Catholic School  
11242 Racetrack Road  
Berlin, Maryland 21811  
410-208-1600

**PARENT OBSERVATION FORM  
FOR PRE-SCHOOL and KINDERGARTEN**

Name of Child \_\_\_\_\_ Birthdate \_\_\_\_\_

Parent's Name \_\_\_\_\_

Address \_\_\_\_\_

Daytime Telephone Number: \_\_\_\_\_

Occupation (Father's) \_\_\_\_\_

(Mother's) \_\_\_\_\_

Child's family includes:

Brothers (name(s) and age(s))

Sisters (name(s) and age(s))

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Pre-school attended \_\_\_\_\_

Teacher's name \_\_\_\_\_ Phone \_\_\_\_\_

Please answer the questions on this form in the best way that you can. You will be able to answer some quite easily and you will have difficulty in making a decision on others.

Your answers on this form will help the school staff and will involve you in deciding with the teacher what kind of educational program is best suited for your child.

This questionnaire is confidential and your responses will be shared only with professional personnel and only if the information learned will help in planning an educational program for your child.

**I. General Health History**

Please check any health concerns that you or your doctor observed:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Bed wetting             | <input type="checkbox"/> Loss of consciousness                    |
| <input type="checkbox"/> Indigestion         | <input type="checkbox"/> Allergies               | <input type="checkbox"/> Chronic ear infections (2+ per year)     |
| <input type="checkbox"/> Constipation        | <input type="checkbox"/> Serious blow(s) to head | <input type="checkbox"/> Overtired or lacking pep                 |
| <input type="checkbox"/> Diarrhea            | <input type="checkbox"/> Headaches               | <input type="checkbox"/> Vomiting                                 |
| <input type="checkbox"/> Nightmares          | <input type="checkbox"/> Heart trouble           | <input type="checkbox"/> Stomachaches                             |
| <input type="checkbox"/> Thumbsucking        | <input type="checkbox"/> Hyperactivity           | <input type="checkbox"/> Frequent fevers                          |
| <input type="checkbox"/> Nail biting         | <input type="checkbox"/> Sinus trouble           | <input type="checkbox"/> Medical problems immediately after birth |
| <input type="checkbox"/> Epilepsy (seizures) | <input type="checkbox"/> Nose bleeding           | <input type="checkbox"/> Diabetes                                 |
| <input type="checkbox"/> Fainting            |  |   |

Other physical problems (explain): \_\_\_\_\_  
\_\_\_\_\_

Is your child presently on medication? \_\_\_\_\_ What? \_\_\_\_\_

Has child had any significant injuries or hospitalization? \_\_\_\_\_

Is child "healthy" on day of screening? \_\_\_\_\_

**II. Hearing Assessment**

Has child ever had any ear/hearing examination or treatment? (Mark one) Yes  No

If yes, when \_\_\_\_\_ By whom \_\_\_\_\_ Results \_\_\_\_\_

	YES	NO
A. Do you suspect any hearing problems	_____	_____
B. Does your child:		
1. Seem to have difficulty hearing?	_____	_____
2. Turn up the TV louder than other members of the family?	_____	_____
3. Seem to favor one ear over the other?	_____	_____
4. Jump or appear to be more startled than others if there is sudden noise?	_____	_____
5. Seem to hear you if you talk in a whisper?	_____	_____
6. Make you talk loudly or repeat frequently?	_____	_____
7. Become confused in following more than two verbal directions at a time?	_____	_____
8. Have difficulty remembering things for a long time?	_____	_____
9. Have difficulty remembering things for a short time?	_____	_____

C. Were the pregnancy and birth of this child  normal  difficult?

Please explain: \_\_\_\_\_  
\_\_\_\_\_

**III. Language Development**

At what age did your child first begin to speak? Give approximate age if you do not remember exact age:

First words \_\_\_\_\_

Two or three words together \_\_\_\_\_

Sentences \_\_\_\_\_

Does your child:

1. Stutter?  Yes  No

2. Have difficulty expressing ideas and concepts?  Yes  No

**IV. Visual Assessment**

Has your child ever had a vision examination or treatment?  Yes  No

When \_\_\_\_\_ By whom \_\_\_\_\_ Results \_\_\_\_\_

	YES	NO
A. Do you suspect any vision problems	_____	_____
B. Does your child:		
1. Seem to have difficulty seeing small lines or pictures?	_____	_____
2. Seem to have a problem seeing things far away?	_____	_____
3. Squint?	_____	_____
4. Wear glasses?	_____	_____
5. Have eyes that turn in?	_____	_____
6. Have eyes that turn out?	_____	_____
7. Sit very close to television?	_____	_____
8. Rub eyes a lot?	_____	_____
9. Turn head as to use primarily one eye?	_____	_____
10. Lower one side of the head when looking at others?	_____	_____

**V. Motor Development**

Your child began walking at age (if guess, label as such) Age \_\_\_\_\_

	YES	NO
A. Do you feel your child has adequate large muscle coordination	_____	_____
B. Does your child:		
1. Catch a ball thrown to him?	_____	_____
2. Enjoy physical activities?	_____	_____
3. Lose balance, trip and fall more often than normal?	_____	_____
4. Have difficulty running?	_____	_____

**VI. Social Development**

A. Does your child:

	YES	NO
1. Have regular playmates the same age?	_____	_____
2. Have difficulty getting along with other children?	_____	_____
3. Prefer to play with other children instead of alone?	_____	_____
4. Become easily frustrated?	_____	_____
5. Cry often?	_____	_____
6. Have a bad temper?	_____	_____
7. Enjoy cooperating with others?	_____	_____
8. Become frequently irritated or moody?	_____	_____
9. Become upset by changes in routine?	_____	_____
10. Have difficulty dealing with family stress such as illness, death or separation?	_____	_____
11. Demand much individual adult attention?	_____	_____
12. Accept discipline and limits?	_____	_____

**VII. Other**

Is there any other information that will help us understand your child?

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Has your child attended a preschool?  Yes  No \_\_\_\_\_ Number of years

Does your child know how to read?  Yes  No

Does your child know how to write?  Yes  No

Would you like an individual conference with a Most Blessed Sacrament staff member to relate any information you don't feel you can include in this form?  Yes  No

Thank you for your patience in filling out this questionnaire.