SAT Student Information

Name of Student ______________________________Date of Birth___/____/____ Age______Grade____

School_________________________ Form Completed by_________________________ Date____________

Lives with : **Both Parents** **Father** **Mother** **Foster Parent** **Relative** **Peers** **On Own** **Other**

Family members present in the home	Family members NOT present in the home
Name Relationship to child Age	**Name Relationship to child Age**

Rate your child's performance at home on the following items	Good	Adequate	Poor	Not Applicable
Ability to follow two to three step directions				
Memory				
Organizational skills				
Planning Skills				
Understanding what he/she reads				
Understanding what he/she sees				
Understanding what he/she hears				
Ability to learn a new game				
Ability to recall events from the school day				
Ability to recall events from a special event				
Ability to speak clearly				
Ability to read aloud				
Ability to carry on a conversation				
Handwriting skills				
Ability to problem solve				
Ability to explain something he/she learns				
Ability to assemble or repair things				
Artistic ability				
Knows basic math facts				
Completes projects in a timely manner				

Does anyone in your family have a history of medical or physical problems? Yes/No If yes, please explain:____

____

Has anyone in your immediate or extended family had academic or educational problems? Yes/No. If yes, please explain:____

____

____

What problems does your child have at school?

What have you done/tried to help your child with the problem(s)?

How do you think other people (relatives, neighbors) view your child?

In your opinion, what can the school staff do to be the most helpful to your child at this time?

Share the strengths and special abilities your child has that the school staff should know.

Describe the way your child learns best.

Please describe a task you would like to see your child learn in the next six months. List any reasons why you think the task will be easy or difficult for him/her.

How many days a week does your child do homework? How long does he/she spend on daily homework? Is homework completed independently, or with support?

Developmental and Medical History

Length of pregnancy (e.g., full term, 40 weeks, 32 weeks, etc.) ____________________

Length of delivery (number of hours from initial labor pains to birth)_______________

Mother's age when child was born _________ The Child's birth weight _______lbs ______oz

Early Developmental Milestones

At what age did your child first accomplish the following…	Age
Sitting without help	
Crawling	
Walking alone, without assistance	
Using single words (e.g., "mama", "dada", "ball")	
Putting two or more words together (e.g. "mama up")	
Bowel training, day and night	
Bladder training, day and night	

Did any of the following conditions occur during pregnancy/delivery?

Condition	YES	NO
Toxemia/preeclampsia		
Rh factor incompatibility		
Serious illness or injury (if yes, what?)		
Took prescription medications (if yes, what?)		
Took illegal drugs		
Delivery was induced		
Forceps were used during delivery		
Had a breech delivery		
Had a C-Section		
Other problems-please describe		

Did any of the following conditions affect your child during delivery or within the first few days after birth?

Conditions	YES	NO
Injured during delivery		
Cardiopulmonary distress during delivery		
Delivered with cord around their neck		
Had trouble breathing following delivery		
Needed oxygen		
Was cyanotic (turned blue)		
Was jaundiced (turned orange/yellow)		
Had an infection (if yes, what?)		
Had seizures		
Was given medications (if yes, what kinds?)		
Born with a congenital defect		
Was in the hospital more than 7 days		

Infant Health and Temperament

During the first 12 months, was your child……	YES	NO	During the first 12 months, was your child……	YES	NO
Difficult to feed			Affectionate		
Difficult to get to sleep			Sociable		
Colicky			Easy to comfort		
Difficult to put on a schedule			Overactive, in constant motion		
Alert			Difficult to keep busy		
Cheerful			Very stubborn, challenging		

Health History

Approx. date of child's last physical exam:________________________

At any time has your child had the following:

	Never	Past	Present		Never	Past	Present
Asthma				Lengthy hospitalization			
Allergies				Chronic ear infections			
Diabetes, arthritis, or other chronic illnesses				Speech or language problems			
Epilepsy or seizure disorder				Febrile seizure (caused by high fever)			
Hearing difficulties				Eye or vision problems			
Chicken Pox or other common childhood illnesses				Fine motor/ handwriting problems			
Heart or blood pressure problems				Gross motor difficulties, clumsiness			
Sleep problems (falling asleep, staying asleep)				Appetite problems (overeating/under-eating)			
Broken bones				High fevers (over 103)			
Severe cuts requiring stitches				Head injury with loss of consciousness			
Soiling problems				Wetting problems			
Lead poisoning				Surgery? If so, list below:			

Any other health conditions? If so, please explain: ____

____

Does your child have any medical/physical/psychological conditions? Please circle all that apply. When applicable please provide explanation and indicate medication.

Circle all that apply	Medication	Explanation
Vision		
Hearing		
ADHD/ADD		
Head Injury		
Asthma		
Allergies		
Diabetes		
Depression		
Cerebral Palsy		
Other		

Many learning problems in childhood are temporary and are brought on by changes in the life of a child and his/her family. Circle all events that apply.

Move to a new school	Out of home placement	Foster home placement
Change of school	Sibling leaving home	Out of home placement
Repeat of grade	Marriage of sibling	Involvement with the law
Serious illness in family	New person joining family	Family/member in counseling
Death in family	Neighborhood concerns	Homelessness
Divorce/separation of parents	Loss of job	Foster home placement
Change in parent(s) work schedule	Drug/alcohol abuse in home	Other: