Colonial Early Education Program
12 Landers Lane, New Castle, DE 19720
www.colonialschooldistrict.org
Colwyck Office (302) 429-4085
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BACKGROUND HISTORY

Child's Name: _____
First Middle Last

Birthdate: ____/____/____ Age: _____ Gender: M____ F____ Race: _____

Mother's Name: _____ Age: _____

Father's Name: _____ Age: _____

Legal Guardian's Name (if applicable): _____ Age: _____

Person Completing this Form: _____
Name Relationship to child

With whom does the child live? _____
Name Relationship to child

Parent's or Legal Guardian's Street Address:

_____
Street Apt.# (if applicable) City State Zip Code

Parent's or Legal Guardian's Mailing Address (if different from above):

_____
Street Apt.# (if applicable) City State Zip Code

Home Phone: _____ Cell Phone: _____

Work Phone (mother): _____ Work Phone (father): _____

Email: _____

In which school district is your child's home located? _____

Does your child attend a childcare/daycare facility? _____ If yes, which childcare/daycare facility?_

_____
Name of facility Address of facility

Language(s) spoken in the home: _____

Other adults living in the home;

_____ _____

Name Relationship Name Relationship

Other children living in the home:

Name_____ Age: _____ Relationship_____

Name_____ Age: _____ Relationship_____

Name_____ Age: _____ Relationship_____

Name_____ Age: _____ Relationship_____

BIRTH HISTORY

Were there any problems during pregnancy? Yes _____ No_____

If yes, please explain _____

_____

_____

_____

_____

Length of pregnancy: Full Term_____ Premature_____ _____

How many weeks?

Type of delivery: Normal_____ Breech_____ Forceps_____ Caesarean_____

Birth Weight: _____ Baby's condition at birth: _____

Any complications during delivery? Yes _____ No_____

If yes, please explain: _____

_____

_____

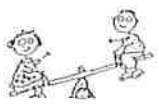
Length of hospital stay: _____

Any complications during hospital stay? Yes _____ No_____

If yes, please explain: _____

_____

_____



HEALTH HISTORY

Name of your child's physician: _____
First Last

Physician's telephone number: (___) _____

Has your child's hearing been tested? Yes _____ No_____ If yes, when? _____

Results of testing: _____

Does your child have a history of ear infections? Yes _____ No_____

If yes, when was the first ear infection? _____ When was the most recent infection? _____

How often has your child had ear infections?

Frequently_____ Occasionally_____ Seldom_____ Never_____

Has your child ever had tubes surgically placed? _____

Has your child's vision been tested? Yes _____ No_____ If yes, when? _____

What were the results of the testing? _____

Are there any other physicians or specialists who have treated your child? If yes, please list:

_____
Name Address Telephone Number

_____
Name Address Telephone Number

_____
Name Address Telephone Number

Does your child have any significant health problems? Yes _____ No_____

If yes, explain _____

_____

_____

Is your child currently taking any medications? Yes _____ No_____

If yes, please list: _____

_____

_____

CHILD'S DEVELOPMENT

Do you have concerns about your child's development? Yes _____ No_____

If yes, explain: _____

_____

_____

Is your child toilet trained? Yes _____ No_____ If yes, at what age did he/she train? _____

Does your child regularly drink from an open cup? Yes _____ No_____

If no, what does he/she use? _____

Did/does your child have frequent use of a pacifier? Yes _____ No_____

Does your child have a history of choking or difficulty swallowing? Yes _____ No_____

If yes, explain: _____

_____

_____

Has your child ever received special education services (including early childhood, speech therapy, occupational therapy, physical therapy)? Yes _____ No_____

If yes, please list:

Type of service	When	Where
Type of service	When	Where
Type of service	When	Where

SPEECH AND LANGUAGE DEVELOPMENT

When did your child first use his/her first words meaningfully? _____

How does your child most frequently communicate with you? Check all that apply:

Sounds_____ Single Words_____ Phrases or Sentences_____ Gestures_____ Pointing_____

Leads to desired objects_____ Other(please describe)_____

How well is your child understood by others?

Parents	Poor_____	Fair_____	Well_____
Siblings	Poor_____	Fair_____	Well_____
Playmates	Poor_____	Fair_____	Well_____

Does your child use at least 50 words? Yes _____ No_____ If no, how many words? _____

___

Is your child able to have a simple conversation with you? Yes _____ No_____

Does your child have difficulty understanding other's questions or following directions? Yes ___ No_____

If yes, when have you observed this? _____

_____

_____

If your child has difficulty understanding or communicating, how does he/she react to this difficulty?

_____

_____

What has been the general course of communication difficulty?

Getting better _____ Remained the same _____ Getting worse _____

CHILD'S BEHAVIOR

What are your child's favorite activities or toys? _____

_____

Is your child able to play by himself/herself for a short time? Yes ___ No___

Does your child like to play with other children? Yes ___ No___

Please describe any frequent behavior problems that you may have with your child: _____

_____

_____

_____

What are your child's strengths? _____

_____

_____

_____

FAMILY HISTORY

Is there a family history of speech, language or learning problems? Yes ___ No___

If yes, please describe the type of problem and who had the problem: _____

_____

_____

_____

_____

_____

_____

DAYCARE AND PRESCHOOL HISTORY

If your child attends a **daycare**, please answer the following:

Type: Public_____ Private_____ Home_____ Family Member's Home_____

Name of Daycare: _____

Address: _____

Telephone Number: _____

Contact Person: _____

How many days and hours does your child attend daycare? _____ days per week, _____ hours per day.

Has the daycare provider expressed any concerns about your child? Yes ___ No____

If yes, please explain:_____

_____

If your child attends **preschool**, please answer the following:

Type: Public_____ Private_____ Home_____

Name of Preschool: _____

Address: _____

Telephone Number: _____

Contact Person: _____

How many days and hours does your child attend preschool? _____ days per week, _____ hours per day.

Have the preschool teachers expressed any concerns about your child? Yes ___ No____

If yes, please explain:_____

_____

Has your child recently changed daycare or preschool settings? Yes ___ No___

If yes, please explain: _____

_____

_____

Is there anything else you would like the assessment team to know about your child or family? _____

_____

_____

_____

_____

_____

_____

Culture

It is important to Colonial School District staff members to be respectful to and understanding of all of our families. Please answer the following cultural questions so that we may understand and support your child and your family.

List any special holidays, customs, or celebrations that are important to your child or your family:

List any food items that your child or your family does not eat due to cultural or religious reasons:

List any religious or cultural beliefs that your family has or any information that you would like to share to help our staff better understand your culture and beliefs:

List all languages your child is learning or exposed to in the home: