Student Intervention Team (SIT) **Form E**

Information from Parents

Name _____ SSN _____ Medicaid #_____

School _____ Grade _____ DOB _____

Address _____ Phone # _____ Emergency #_____

Parents were contacted by ☐ Letter ☐ Telephone ☐ Conference

Parents were contacted by _____ on _____

(School staff) (Date)

Family

With whom does the student live?
Who has legal authority to make educational decisions for this child?

Primary language spoken in the home_____Other languages spoken_____

Father's name	Age	Occupation	Mother's name	Age	Occupation
Father's employer	Work phone number		Mother's employer	Work phone number	
Father's highest grade completed:			Mother's highest grade completed:		
Father's learning, attention, behavior, or medical problems? If so, please specify.			Mother's learning, attention, behavior, or medical problems? If so, please specify.		
Other children in the home	Age	Relationship	Other adults in the home	Age	Relationship

Have any of your blood relatives experienced problems similar to those your child is experiencing? ☐ Yes ☐ No

If yes, please describe:

_____

_____

_____

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Child Behaviors

What are some of your child's strengths?

Do you feel that your child is experiencing problems in school? What kind of problems?

When were you first aware of the problem?

What do you think is causing the problem?

Has your child mentioned problems with school? How does he/she feel about the problem?

Please describe your child's behavior at home. (For example, is he/she generally well-behaved? Have there been any recent changes in behavior? How does he/she get along with other family members, neighbors, and friends?)

What does your child do when not in school? (For example, watch TV, read, do chores, work at part-time job, play with other children.)

What activities does the family do together? (For example, watch TV, go camping, participate in hobbies, sports.)

What methods of discipline are used with your child at home? (For example, spanking, extra chores, early bedtime, removal of TV and other privileges, rewards for good behavior.)

_____

_____

_____

What is your child's reaction to discipline?

_____

_____

_____

Have there been any important changes within the family? (For example, parent job changes, moves, births, deaths, illnesses, accidents, separations, divorce, remarriage, abuse incidents.)

_____

_____

_____

Briefly discuss any other important information about your child.

_____

_____

_____

Health and Developmental History

Were there any problems before, during, or immediately after birth? ☐ Yes ☐ No
If yes, please explain.

_____

_____

_____

Compared with other children in the family, the child's development has been:
☐ slower ☐ about the same ☐ faster

Describe any problems during infancy or early childhood with feeding, sleeping, or other areas such as difficulty being comforted, excessive restlessness or irritability, colicky, etc.

_____

_____

Circle below the characteristics of your child 's temperament when he/she was an infant and a toddler.

Activity level	Low	Average	High
Attention level	Low	Average	High
Adaptability—Dealing with changes	Poor	Good	Very good
Approach/withdrawal—Responding to new things (e.g., places, people, food, etc.)	Poor	Good	Very good
Mood—What was your child's basic mood?	Unhappy	Average	Very happy
Regularity—How predictable was your child in patterns of sleep, appetite, etc.?	Not predictable	Somewhat predictable	Very predictable

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Briefly describe any childhood illnesses (e.g., measles, chicken pox, chronic ear infections, allergies, high fevers, or seizures), accidents (e.g., head injury, broken bones, stitches), and hospitalizations. Please give your child's age at the time of illness, accident, or hospitalization.

_____

_____

_____

Is your child under the care of a physician for a medical problem? ☐ Yes ☐ No If yes, please explain.

_____

_____

_____

Please indicate the date and results of your child's latest physical examination.

_____

_____

_____

Is your child now taking medicine? ☐ Yes ☐ No If yes, please describe reason for medication, type, dosage, and effect and side effects the medicine might have.

_____

_____

Has your child ever taken medicine for a long period of time? ☐ Yes ☐ No If yes, please explain the reasons and effect.

_____

_____

Does you child use any special equipment or technology to improve functioning? ☐ Yes ☐ No
If yes, please explain.

_____

_____

Is your child receiving services from another agency (e.g., tutoring, counseling, probation monitoring, etc.)?
☐ Yes ☐ No If yes, please explain.

_____

_____

Has your child ever been evaluated before for neurological, psychological, psychiatric, speech language, learning, hearing, vision, or physical problems in the past? ☐ Yes ☐ No If yes, please explain and indicate dates of assessments.

_____

_____

Would you be interested in parent training? ☐ Yes ☐ No If yes, in what areas?

_____

_____ _____
Signature Date