The School District of Osceola County

Pre-School Educational Evaluation Program (PEEP)

Child Information Form

Demographics:

Child's Legal Name_____ Date of Birth____/____/____ Sex: ☐Male ☐ Female

Home address_____Apartment_____City_____Zip _____

Federal Ethnic Category: (please select **one**) ☐Hispanic/Latino ☐Non-Hispanic/Non-Latino

Federal Race Category: (mark **all** that apply)

☐White ☐Black/African American ☐Asian

☐Native Hawaiian/other Pacific Islanders ☐American Indian/Alaskan Native

Primary language(s) spoken in the home: Parents:_____ Child:_____

Parent #1 Name_____ Parent #2 Name_____

Phone Number_____ Phone Number_____

Parent #1 email address_____ Parent #2 email address_____

☐lives with ☐lives with

Who has legal custody of the child? ☐both parents ☐ mother ☐ father ☐ other_____

Does your child have a Guardian ad Litem? ☐yes ☐ no Is your child in foster care? ☐yes ☐ no

Siblings: ☐n/a

Name:_____Age_____ School:_____

Name:_____Age_____ School:_____

Name:_____Age_____ School:_____

Name:_____Age_____ School: :_____

Is your child presently receiving any of the following services? ☐yes ☐no

Was your child dismissed from any therapy services? _____

Previous/Current Support Services

☐Speech/Language Therapy	times per week:_____	provider:_____
☐Occupational Therapy	times per week:_____	provider:_____
☐Physical Therapy	times per week:_____	provider:_____
☐Oral/Motor Therapy	times per week:_____	provider:_____
☐Behavior Therapy/ABA	times per week:_____	provider:_____
☐Early Intervention Therapy	times per week:_____	provider:_____

The School District of Osceola County

Pre-School Educational Evaluation Program (PEEP)

Child Information Form

Birth/Medical History

Is your child adopted? ☐yes ☐ no I f yes, at what age_____

Did the child have prenatal care during the first trimester?

☐yes ☐ no ☐unknown

Was the fetus exposed to the following: ☐alcohol ☐ tobacco ☐ medications ☐drugs ☐ trauma ☐other

Gestation: ☐full term ☐ premature___weeks ☐post term___weeks Birth Weight:___pounds____ounces

Childbirth: ☐natural ☐cesarean

Length of stay in hospital_____ Length of stay in NICU: _____

Describe any illnesses, complications, and/or hospitalizations during pregnancy/birth:

_____

What medical diagnoses apply to your child:

☐multiple birth ☐ required oxygen at birth ☐ cord around the neck ☐ jaundice ☐meconium aspiration

☐birth injury ☐ seizures ☐ Cerebral Palsy ☐ Autism/PDD ☐ADHD/ADD ☐ chronic ear infections

☐PE tubes ☐ syndrome(s)_____☐surgeries_____

☐allergies_____ ☐head injuries_____☐accident(s)_____

☐other _____

Current medications_____

Vision/Hearing

Do you have concerns with your child's: ☐vision ☐ hearing ☐no concerns

Has your child been diagnosed with vision or hearing problems? ☐yes ☐no Explain:_____

Date of most recent hearing screening:_____ Results: ☐pass ☐fail Concerns:_____

Does your child wear hearing aids? ☐yes ☐ no Is your child followed by an ear doctor? ☐yes ☐no

Date of most recent vision screening: _____ Results: ☐pass ☐fail

Does your child wear glasses? ☐yes ☐ no Is your child followed by a vision doctor? ☐yes ☐no

Concerns:

_____

_____

The School District of Osceola County

Pre-School Educational Evaluation Program (PEEP)

Child Information From

Developmental Milestones:

Please indicate in **months** when your child mastered the following skills:
Sat alone___ crawled ___ walked ___ potty trained ___ spoke first word.___ combined words _____

Is there a family history of: ☐special education ☐mental illness ☐ autism ☐learning problems
☐n/a ☐behavior problems ☐significant medical history ☐other _____

What is your primary concern?
Do you have concerns with (or has anyone else mentioned) any of the following (check all that apply):
☐ADD/ADHD ☐autism ☐sensory ☐behavior ☐anxiety ☐learning difficulties ☐communication

Other:_____

Self-help Concerns: ☐no concerns
☐safety ☐feeding ☐toilet training ☐no fear ☐runs off ☐requires constant supervision
Additional comments:_____

Personal/Social Concerns: ☐no concerns
☐poor eye contact ☐ignores name when called ☐prefers to play alone ☐resists being held or touched
☐grabs/takes toys from others ☐aggressive ☐upset by changes in routines ☐demands attention

☐frequent tantrums/meltdowns ☐easily frustrated ☐repeatedly lining up toys/objects
☐defiant/refuses to cooperate ☐impulsive ☐difficulty keeping hands/feet to self
Additional comments:_____

Motor/Mobility Concerns: ☐no concerns
☐not walking I f not walking, what is the mode of mobility? ☐rolling ☐ crawling ☐scooting
☐falls often ☐clumsy ☐repeatedly toe-walks ☐tires easily
Does your child have any adaptive equipment? ☐No ☐walker ☐wheelchair ☐braces ☐hand splints
☐helmet Additional comments:_____

Learning/Readiness Concerns: ☐no concerns
☐short attention ☐selective interest in toys ☐easily distracted ☐concerns with pre-academics
☐struggling at preschool/daycare ☐difficulty following directions ☐difficulty answering basic questions
Additional comments:_____

The School District of Osceola County

Pre-School Educational Evaluation Program (PEEP)

Child Information From

Sensory Concerns: ☐no concerns

☐repeatedly hand flapping ☐difficulty sitting still ☐spins/runs in circles ☐picky eater
☐bothered by loud noises ☐bothered by tags in clothing ☐stares ☐repeatedly rocks ☐plays rough
☐mouthing objects ☐poor safety awareness ☐restricted interests ☐lines up toys

Communication Concerns: ☐no concerns

☐not talking ☐speech started and then stopped ☐hard to understand
☐repeats or echoes what others have said ☐repeats phrases from movies, TV shows, videos, etc.
Primary mode of communication: ☐sentences ☐ words ☐ gibberish/jargon ☐ pointing ☐ leading
Additional comments:_____

Preschool/Childcare Experience:

Does your child currently attend:

☐preschool ☐childcare
☐in-home childcare ☐VPK
☐ Early Head Start ☐Head Start

Name of preschool/childcare:_____
Phone number:_____
Address:_____
City: _____Zip code:_____

Additional Notes:

_____
_____
_____
_____

The School District of Osceola County

Pre-School Educational Evaluation Program (PEEP)

Child Information From

Home Language Survey

1. Is a language other than English used in the home? _____

2. Did the student have a first language other than English? _____

3. Does the student most frequently speak a language other than English?

_____

4. What is the language most frequently spoken at home? _____

5. What is the student's country of origin? _____

6. Which language did your son/daughter learn when he/she first began to talk? _____

7. What language do you most frequently speak to your son/daughter?

(Father) _____

(Mother) _____

8. Please describe the language understood by your child. (Check only one)

□ A. Understands only the home language and no English

□ B. Understands mostly the home language and some English.

□ C. Understands the home language and English equally.

□ D. Understands mostly English and some of the home language.

□ E. Understands English only.

9. If available, in what language would you prefer to

receive communication from the school? _____

Parent or Guardian's Name: _____ Date: _____