

**BROOKFIELD PUBLIC SCHOOLS
DEVELOPMENTAL HISTORY**

<hr/> Student's Last Name	<hr/> First Name	<hr/> Middle Name	<hr/> Gender	<hr/> Birth Date
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Please check all areas that apply to your child and explain below:

- | | |
|---|---|
| <input type="checkbox"/> Pregnancy complication | <input type="checkbox"/> Over/under active |
| <input type="checkbox"/> Birth injury/complication | <input type="checkbox"/> Poor appetite/eating problem |
| <input type="checkbox"/> Premature birth at _____ weeks | <input type="checkbox"/> Sleeping difficulty |
| <input type="checkbox"/> Complications after birth | <input type="checkbox"/> Tires easily |
| | <input type="checkbox"/> Toileting problem |

Explain: _____

DEVELOPMENTAL MILESTONES

At what age did your child:

_____ Sit up alone	_____ Use single words	_____ Toilet trained
_____ Crawl	_____ Use 2-4 word sentences	_____ Ride a bicycle
_____ Walk alone	_____ Sleep through the night	_____

Has your child been evaluated by the birth to three program? _____

Does your child have any developmental concerns that have required an evaluation by a specialist (speech pathologist, occupational or physical therapist, psychologist, psychiatrist etc)? If so, explain: _____

My child's development has been similar to his/her peers: ____yes ____no

If no, explain: _____

Do you think your child has a fine or gross motor problem? ____yes ____no

If yes, explain: _____

Do you think your child has a speech or language problem? ____yes ____no

If yes, explain: _____

SOCIAL AND EMOTIONAL DEVELOPMENT (Please check areas that apply to your child and comment below):

- | | |
|---|---|
| <input type="checkbox"/> Cries easily | <input type="checkbox"/> Has one or more good friends |
| <input type="checkbox"/> Bites nails | <input type="checkbox"/> Is quiet or shy |
| <input type="checkbox"/> Sucks thumb | <input type="checkbox"/> Is confident |
| <input type="checkbox"/> Gets angry easily | <input type="checkbox"/> Joins group activities |
| <input type="checkbox"/> Has a hard time focusing | <input type="checkbox"/> Plays easily with peers |
| <input type="checkbox"/> Daydreams | <input type="checkbox"/> Prefers solitary play |
| <input type="checkbox"/> Has nightmares | <input type="checkbox"/> Shares easily |
| <input type="checkbox"/> Has temper tantrums | <input type="checkbox"/> Sticks to tasks |
| <input type="checkbox"/> Is impulsive | <input type="checkbox"/> Tolerates changes in routine |
| <input type="checkbox"/> Is moody | <input type="checkbox"/> Usually seems happy |
| <input type="checkbox"/> Is aggressive | <input type="checkbox"/> Is affectionate |

Comment: _____

Does your child have any fears or anxieties that may interfere with learning at school?

Is there anything you feel we should know about your child in order to help him/her make a satisfactory adjustment to school? _____

FAMILY AND HOME BACKGROUND

Is there any relevant information we should know regarding the home? Please include things such as recent moves, job changes, death in the family, divorce, adoption/birth etc.

Student's primary language: _____ Other languages spoken at home: _____

Other children (names and ages): _____

Parent/Guardian Signature
9/06

Date

Parent/Guardian Signature

Date

BROOKFIELD PUBLIC SCHOOL
PRESCHOOL INFORMATION SHEET

Parents: Please fill in your child's name, birth date, address, and the preschool he/she is attending. (If your child is not attending preschool this year, print "none".) Please sign the "release information" permission request and return this form with your packet.

Child's Name: _____

Date of Birth: _____

Address: _____

Preschool: _____

Address: _____

Permission for release of information

Parent's signature: _____

(This portion to be filled out by preschool teachers)

Preschool Teachers:

We have been informed that the above child is enrolled in your preschool program. Therefore, we ask that you please take a few moments to consider the following skill areas and check the appropriate item. Please feel free to add comments indicating particular strengths or weaknesses that you have observed.

	Above Age Level	Age Level	Below Age Level
SELF HELP SKILLS: Ability to toilet, feed, and dress with minimal assistance.	_____	_____	_____

Comments: _____

SOCIALIZATION (Behavior): Shows evidence of self-control, awareness of rules and consequences, plays cooperatively with peers, and responds appropriately to adult directions.

_____	_____	_____
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Comments: _____

EMOTIONAL: Please indicate child's general temperament and/or predictable emotional responses, such as: outgoing, generally quiet or shy, fearful of loud noises, needs frequent encouragement, etc.

_____	_____	_____
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Comments: _____

	Above Age Level	Age Level	Below Age Level
<u>LANGUAGE: (Oral Communication):</u> Use of phrases and sentences with proper grammar and parts of speech; evidence of clear thought patterns.	_____	_____	_____

Comments: _____

<u>SPEECH (Articulation):</u> Control of oral in space and in relation to objects, balance, agility, and general coordination.	_____	_____	_____
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Comments: _____

<u>GROSS MOTOR:</u> Child's ability to control body in space and in relation to objects, balance, agility, and general coordination.	_____	_____	_____
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Comments: _____

<u>FINE MOTOR:</u> Eye-hand coordination; ability to control small muscles of the hand for manipulation of pencil, scissors, small objects, etc.	_____	_____	_____
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Comments: _____

<u>PRE-ACADEMIC (Cognitive Skills):</u> Willingness to attend to group discussion and instruction: ability to follow directions and work somewhat independently	_____	_____	_____
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Comments: _____

1. Please indicate any additional concerns or comments regarding this child: _____

2. If you have any concerns, are the parents aware of them? What are the parents' feelings about these concerns?

3. At this time, do you feel it is necessary to be contacted by the school personnel to discuss this child further?

Please attach copies of any evaluations you have conducted on this child or other information you feel is pertinent.