ROWAN UNIVERSITY

Glassboro, New Jersey
(856) 256-4769

ROWAN UNIVERSITY READING CLINIC
PARENT FORM

Student Name ______________________________ Date ____________________

Current Grade ______________________________ Birth Date __________________

Name of Parents ____________________________ Phone ____________________

Address ____

____

School Name ______________________________ Sex (   ) Male   (   ) Female

School Address ____

Greatest concerns about your child's reading: ____________________________________

____

This form is intended to provide information which will be helpful to us in planning appropriate instruction. Please answer all questions as fully as possible and return this form in the enclosed envelope with the registration form.

List three positive things about your child:

____

____

____

Family Background

Child lives with: Mother ___ Father ___ Both ___ Other ___
Are both parents living? _____
How often has family moved during student's life?_____ How old was he\she at these times _____
Does the student have siblings?____ If so what are the ages of the siblings____________________
Do any other persons live in home?____ If yes, list below-names, ages, relation to child.

____

To which racial or ethnic group do you most closely identify?
African-American (   ) Latino or Hispanic (   ) Asian/Pacific Islander (   )
Native America or Aleutian (   ) Caucasian (Non-Hispanic) (   )
Other ____

Is any language other than English spoken in the home? ______________________________

Medical History

List childhood diseases and serious injuries and ages at which they occurred:____________

____

Present height and weight:____________ Has child ever had any unusual spells, seizures, sleepwalking, nervousness, upset stomach, etc.? ______________________________________

Has child worn glasses? _______ When did he\she begin to wear them?_______________

What is the nature of the visual defect? ____

When was child's vision last checked?____

Have any hearing defects ever been reported?____

Does the child have a history of ear infections?______ When did they begin?_____________

When did they cease to be a problem?_______ How were they treated?_________________

Date of last physical examination_______ Does child have any physical handicap?________

If so, describe____

Is your child taking any medication on a regular basis? ____ If so, what medication and for what purpose?____

School History

Did child attend kindergarten?_______ Age at entrance into first grade_______

Has the child had any extended absences from school?_______ If so, when and for what reason____

Has child changed schools frequently?_________ In what grades?__________

Reason:____

Has child failed any grades?______ Which?________Has child skipped any grade?_______

When was difficulty first noted?____

Has the child had any special help with this difficulty?______________________________

In what school subject does student receive best grades?____________________________

Poorest grades?__________________ Describe any testing your child has had___________

____

Activities, Interests, Attitudes

List child's hobbies, clubs, organizations, activities:__________________________________

____

Does the child choose to read at home?____

What is the average time child spends watching TV each day?________________________

What books or magazines does the child like to read?_______________________________

____

Any other information that you feel would be helpful to us___________________________

____

Signed ___________________________________

(Parent)