Child's name: ________________________  Child's Class: _________________________

Name of Parent/Guardian who is completing this survey: _____________________________

How is your child with activities of daily living (basic self care tasks such as feeding, toileting, grooming, etc.)?
____________________________________________________________________________
____________________________________________________________________________

Does your child have any chores or responsibilities at home? If so, what are they?
____________________________________________________________________________
____________________________________________________________________________

What is your child’s learning style?
____________________________________________________________________________
____________________________________________________________________________

Please share your child’s academic interests, preferences, and strengths:
____________________________________________________________________________
____________________________________________________________________________

What are some of the academic concerns that you have regarding your child? What do you feel that your child struggles with academically?
____________________________________________________________________________
____________________________________________________________________________

Please share your child’s social strengths and weaknesses (Do they struggle to make friends?/Do they make friends easily? Is he/she sensitive or shy? Is he/she very outgoing? etc.)
____________________________________________________________________________
____________________________________________________________________________

Do you have any concerns about your child’s social development?
____________________________________________________________________________
____________________________________________________________________________

Please share about your child’s physical development (motor and sensory development, health, vitality, physical skills or limitations which can impact the learning process):
____________________________________________________________________________
____________________________________________________________________________

Does your child wear prescription eye glasses? yes  no

*Does your child have any allergies? _____________ If yes, what are they? _______________

Does your child have asthma? yes  no

Do you have any concerns about your child’s physical development?
____________________________________________________________________________