

**John Glenn School Corporation
Special Education Department**

REEVALUATION SOCIAL AND DEVELOPMENTAL HISTORY

(To determine eligibility under a different or additional category this form must be used. For other reevaluations this form is optional)

Student's Name _____ STN _____

Birthdate _____ Age _____ Sex (circle one): Male Female

Home Address _____ Phone _____

School _____ Grade _____

Person completing this form: (Circle one): Natural Mother, Natural Father, Foster Parent, Stepmother, Stepfather, Adoptive Parent or Other (Please explain): _____

Marital status of biological parents: _____

If separated or divorced, how old was child at separation _____ at divorce _____

Who has custody of this child? _____ Does the child have contact with the non-custodial parent? _____

How often does the non-custodial parent see this child? (Circle one): At least Weekly, Monthly, Few times each Year, or Never

Is either biological parent deceased? Mother _____ Father _____ If Yes, indicate the year _____

List all brothers and sisters, or others living with the family and their relationship to the child:

Name	Age	Sex	Relationship to child	Living in home?	Living outside home?

Has the student been involved in any of the following settings? If yes, indicate the dates: Foster Home _____

Group Home _____ Correctional Facility _____ Psychiatric Facility _____

Independent Living Situation _____ Other (specify) _____

MEDICAL HISTORY

Is the child currently on any medication at this time? Yes _____ No _____. If yes, list information.

Medication	Dosage	Dispensed at		Diagnosis and Reason for Medication
		Home	School	

List any chronic medical conditions: _____

Please explain the illness or condition and any side effects: _____

Name of child's doctor _____ Address _____

Date of last physician examination _____ Does the physician know of the child's school problems? _____

Physician's comments about school problems: _____

SPECIAL FACTORS

VISION:

____ No apparent problem
____ Vision Examination
(Date _____ by whom _____)
____ Wears glasses
____ Wears contacts
____ Had surgery (specify: _____ age _____)

HEARING:

____ No apparent problem
____ Hearing Examination
(Date _____ by whom _____)
____ Had surgery (specify _____ age _____)
____ Ear infections/frequency _____
____ Hearing loss/Age of loss _____

GROSS AND FINE MOTOR:

____ No apparent problem
____ OT or PT Examination
(Date _____ by whom _____)
____ Walking, jumping, running problems
____ Cutting, writing, coloring, printing problems
____ Other (specify _____)

COMMUNICATION:

____ No apparent problem
____ Speech and Language Examination
(Date _____ by whom _____)
____ Problems expressing thoughts
____ Problems pronouncing words
____ Other (specify _____)

SOCIAL:

How does your child interact with other children (list any fights, play groups, friends, trouble, etc.)? _____

How does your child get along with adults? _____

Have you noticed any unusual social interactions? Yes ___ No ___ Please explain: _____

SCHOOL HISTORY

What school(s) has your child attended since the last three-year evaluation? Please list: _____

SCHOOL INTERVENTIONS

List any school interventions that have occurred in the last three years, such as: remediation, summer school or repeat grade.

AGENCY SERVICES

List the agencies that have provided services for your child in the last three years, such as: private tutoring, counseling, community service agency, mental health agency, Department of Children and Families, court system, day treatment program, inpatient psychiatric hospital.

Do you have any other questions or concerns you want addressed in the evaluation? _____

How long has this been a concern to you? _____

Any other information that would help us understand you child? _____