COUGAR LITERACY CLINIC
Southern Illinois University Edwardsville
Founders Hall Room 1317, Campus Box 1122
Edwardsville, Illinois 62026-1122
(618) 650-3082, FAX 618 650-3485, or smcandr@siue.edu

For Office Use Only
Date Received:

FAMILY FORM

This form along with the Teacher Form is required for the application to the Cougar Literacy Clinic. It is intended to provide information which will be helpful to us in understanding your child. Please answer as fully as possible and return to the above address. Thank you!

Child's Name:_____ Age:_____ Date of Birth:_____

Address:_____ Phone:_____

City:_____ State:_____ Zip Code:_____

School:_____ District: _____ Grade:_____

FAMILY DATA

	FATHER OR GUARDIAN	MOTHER OR GUARDIAN
Name:	_____	_____
Work Place:	_____	_____
Work Phone:	_____	_____
Cell Phone:	_____	_____
E-mail:	_____	_____

Names of Brothers and Sisters:	Age	Grade or Occupation
_____	_____	_____
_____	_____	_____
_____	_____	_____

Language other than English spoken in the home _____

COUGAR LITERACY CLINIC TESTING AUTHORIZATION

I give permission for SIUE literacy clinicians and faculty to administer and analyze ability, achievement, and diagnostic assessments to my child _____. I give permission for my child to be audio and video recorded and photographed during sessions. I give permission for clinicians to prepare a case report on my child's literacy development, providing copies for me and his/her school. I understand that this information will be used for the purposes of instruction, assessment and research.

SIGNATURE _____ DATE_____

DEVELOPMENTAL HISTORY

Does your child have any health problems? _____ If so, please describe them:_____

_____

Date of last physical exam _____ Does your child currently take any medications? _____

If so, please specify and explain their purpose: _____

Does your child have a physical disability? _____ If so, please describe: _____

_____

List complications at birth, serious illnesses, injuries or surgeries and the age at which each occurred:

_____

_____

Does your child have any difficulties with fine motor skills (writing, holding a pencil, cutting)?_____

Is your child: _____right-handed *or* _____ left-handed? Does he/she change use of hands? _____

Does your child have any vision problems? _____ If so, please describe:_____

_____

Does your child wear glasses or contacts? _____ If so, when did he/she begin to wear them? _____

Date of last vision exam _____ By whom? _____(Optometrist, Family Doctor, School Personnel)

Does your child have any hearing problems? _____ If so, please describe _____

_____

Does your child wear hearing aides? _____

Date of last hearing test _____ By whom? _____(Audiologist, Family Doctor, School Personnel)

Did or does your child have any delays in language development? _____ If so, please describe_____

_____

Does your child have any speech problems? _____ If so, please describe: _____

_____

Has your child had a psychological exam? _____ Date of exam _____

Examined by whom? _____(school or private)

EDUCATIONAL HISTORY

How is your child doing in school? _____

When was the difficulty in reading and/or writing first noticed? _____

What were the initial concerns?_____

Has your child ever received any special services at school (Reading, Writing, Math, Speech, Language, Special Education- Learning Disability, Behavioral Disability, Physical Therapy, Occupational Therapy)_____

_____

When?_____ How often? _____, How much time per day? _____,

Does your child have an Individualized Education Plan (IEP)? _____ If so, please bring a copy.

Has your child been tutored in reading? _____ By whom? _____

For how long? _____Was it discontinued? _____ How long ago? _____

As compared with other children of your child's age, do you think that your child's general development is:

_____ above average _____average _____below average

Please provide a copy of report cards or any testing results.

BEHAVIOR, INTERESTS, and ATTITUDES

How does he/she get along with other children and adults in the family? _____

How does your child interact with other children? _____

How does your child interact with other adults? _____

Who does he/she play with or hang out with in the neighborhood or at school? _____

_____

What are his/her usual dispositions?_____

(circle all that apply) cheerful, cooperative, unhappy, concerned, sleepy, content, outgoing, complaining, excited, shy, changes moods quickly, frustrated, amused, angry

Is there evidence of any anxiety such as tensions, fears, or insecurity? _____ If so, please describe_____

_____

List your child's hobbies and major activities: _____

_____

How much time does your child spend watching TV or playing video games? _____

In what subjects does your child achieve best? _____

In what subjects does he/she show poorest achievement? _____

What is your child's attitude toward school? _____

ATTITUDE SCALE

Please indicate your observation of your child's reading abilities and attitudes.

A = Strongly Agree **B** = Agree **C** = Disagree **D** = Strongly Disagree

My child:	*Circle One*	*Comments*
1. Can remember and tell you about what he/she reads.	A B C D	
2. Enjoys being read to by family members.	A B C D	
3. Finds time for quiet reading at home.	A B C D	
4. Attempts to figure out words if they don't make sense.	A B C D	

5. Enjoys reading to family members. A B C D
6. Enjoys writing on his/her own (journals, stories) A B C D
7. Wants to write to others (notes, letters, e-mails) A B C D
8. Enjoys sharing his/her writing A B C D
9. Chooses to write about books or topics from school A B C D
10. Is able to complete homework assignments. A B C D

Strengths I see: _____

_____

_____

Areas that need improvement: _____

_____

_____

Concerns or questions I have: _____

_____

_____

Please add any information that you think will be helpful to us in understanding and teaching your child.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Printed name of person filling out form _____

Relationship to child _____

SIGNATURE_____DATE_____