THE SCHOOL BOARD OF BROWARD COUNTY, FLORIDA
PARENT INFORMATION FORM (PIF)

Dear Parents/Caregivers:

The information you provide will assist in planning your child's education. **Your input is very important, so please answer every question as fully and accurately as possible.** If you need assistance, please call the school counselor or ESE specialist at your child's school. Thank you for your cooperation.

I. PERSON COMPLETING THIS FORM

NAME _____ DATE _____

TITLE OR RELATIONSHIP TO THE CHILD _____

II. STUDENT DEMOGRAPHICS

STUDENT _____ SEX _____ BIRTHDATE _____ AGE _____

SCHOOL _____ GRADE _____ TEACHER _____

STUDENT'S CURRENT ADDRESS _____

HOW LONG HAS STUDENT LIVED IN BROWARD COUNTY? _____ AT PRESENT ADDRESS? _____

IS STUDENT LIVING WITH BOTH BIOLOGICAL PARENTS? YES[ ] NO[ ] IF NOT, PLEASE EXPLAIN (AND GIVE DATE OF ADOPTION, SEPARATION, DIVORCE, DEATH, ETC.) _____

DOES STUDENT HAVE CONTACT WITH ANY NON-CUSTODIAL PARENT? YES[ ] NO[ ] FREQUENCY? _____

MOTHER/GUARDIAN	FATHER/GUARDIAN
ADDRESS	ADDRESS
PHONE: Work Cell	PHONE: Work Cell
EMAIL:	EMAIL:
EDUCATION	EDUCATION
OCCUPATION	OCCUPATION
AGE AT CHILD'S BIRTH	AGE AT CHILD'S BIRTH

BROTHER'S/SISTER'S NAMES:	SEX	AGE	LIVING AT HOME	SCHOOL

NAMES OF OTHER PERSONS IN THE HOME: RELATIONSHIP AGE

_____ _____ _____

_____ _____ _____

III. BACKGROUND INFORMATION

PREGNANCY, BIRTH, AND DEVELOPMENTAL HISTORY:

WERE THERE COMPLICATIONS DURING PREGNANCY? (PLEASE EXPLAIN)_____

_____

PREGNANCY_____MONTHS BIRTH WEIGHT_____POUNDS & _____OUNCES

PLEASE DESCRIBE MOTHER'S AND CHILD'S HEALTH DURING AND AFTER BIRTH_____

_____

INDICATE AGE CHILD FIRST:

SAT UP_____ WALKED_____ TOILET TRAINED_____

SPOKE WORDS_____ SPOKE SENTENCES_____

PLEASE EXPLAIN IF YOUR CHILD HAS HAD ANY PROBLEMS IN THE FOLLOWING AREAS OF DEVELOPMENT:

HEARING_____ COORDINATION_____

VISION_____ SPEECH_____

COMMUNICATION_____SOCIALIZATION_____

HAS YOUR CHILD RECEIVED SPEECH/LANGUAGE THERAPY OR ANY OTHER THERAPY IN THE PAST?

YES[ ] NO[ ] EXPLAIN: _____

HEALTH INFORMATION:

INDICATE WHEN CHILD HAD ANY OF THE FOLLOWING:

HIGH FEVER_____ HEADACHES_____

EAR INFECTIONS_____ DIABETES_____

MENINGITIS_____ ASTHMA_____

ALLERGIES _____

SEIZURES (EXPLAIN):_____

ACCIDENTS (EXPLAIN):_____

HEAD INJURY (EXPLAIN):_____

DID YOUR CHILD LOSE CONSCIOUSNESS? NO[ ] YES[ ] HOW LONG? _____

OTHER (EXPLAIN):_____

HAS CHILD EVER BEEN HOSPITALIZED? NO[ ] YES[ ]

REASON_____ AGE_____ FOR HOW LONG?_____

REASON_____ AGE_____ FOR HOW LONG?_____

DOES YOUR CHILD WEAR GLASSES/CONTACT LENSES? NO[ ] YES[ ] DATE OF LAST EXAM_____

DOES YOUR CHILD WEAR A HEARING AID? NO[ ] YES[ ] DATE OF LAST EXAM_____

CHILD'S PHYSICIAN_____ DATE OF LAST EXAM_____

CHILD'S CURRENT HEALTH_____

HAS THE CHILD EVER SEEN ANY OF THE FOLLOWING?

PSYCHOLOGIST: WHO?_____DATE_____ REASON_____

PSYCHIATRIST: WHO?_____DATE_____ REASON_____

NEUROLOGIST: WHO?_____DATE_____ REASON_____

COUNSELOR: WHO?_____DATE_____ REASON_____

WHAT WAS THE OUTCOME/DIAGNOSIS?_____

_____

IS THE CHILD PRESENTLY ON ANY MEDICATION? NO[ ] YES[ ] WHEN STARTED?_____

REASON FOR MEDICATION_____ NAME OF MEDICATION_____

IS THERE ANY FAMILY HISTORY OF MEDICAL OR MENTAL HEALTH PROBLEMS? NO[ ] YES[ ]

EXPLAIN: _____

IS THERE ANY FAMILY HISTORY OF LEARNING PROBLEMS? NO[ ] YES[ ] EXPLAIN:_____

_____

PAST EDUCATIONAL HISTORY:

LIST ALL SCHOOLS THIS STUDENT HAS ATTENDED (INCLUDE PRE-SCHOOL, IF ANY):

NAME OF SCHOOL LOCATION GRADE(S) REASON FOR LEAVING

_____

_____

_____

_____

AGE STUDENT STARTED KINDERGARTEN_____ REPEATED A GRADE? NO[ ] YES[ ]

IF YES, WHAT GRADE?_____ WHY?_____

IV. <u>PRESENT FUNCTIONING</u>

CURRENT EDUCATIONAL FUNCTIONING:

WHAT ARE YOUR CHILD'S FEELINGS TOWARD SCHOOL?_____

_____

_____

WHAT ARE YOUR FEELINGS ABOUT YOUR CHILD'S CURRENT EDUCATIONAL PROGRAM?

_____

_____

IS YOUR CHILD HAVING DIFFICULTIES AT SCHOOL? NO[ ] YES[ ]

IF YES, WHAT DO YOU FEEL IS THE PROBLEM?_____

_____

_____

WHEN & HOW DID THIS PROBLEM BEGIN?_____

_____

HOME FACTORS:

HOW DOES THE STUDENT GET ALONG WITH:

MOTHER_____ SISTERS_____

FATHER_____ BROTHERS_____

CHECK ANY OF THE FOLLOWING WHICH PRESENT A PROBLEM FOR YOUR CHILD AND EXPLAIN BELOW:

[ ] EATING	[ ] SLEEPING	[ ] TOILET ACCIDENTS	[ ] NAIL BITING
[ ] OVER ACTIVITY	[ ] UNDER ACTIVITY	[ ] UNUSUAL FEARS	[ ] NIGHTMARES
[ ] SKIPPING CLASS	[ ] INATTENTIVENESS	[ ] TEMPER OUTBURSTS	[ ] SELF HARM
[ ] ALCOHOL/DRUG USE	[ ] RUNNING AWAY	[ ] FOLLOWING RULES	[ ] WORRYING A LOT
[ ] GETTING ALONG WITH OTHERS		[ ] NERVOUS TWITCHING	[ ] THUMB-SUCKING

[ ] SENSITIVITY TO TOUCH/LIGHT/SOUNDS/TEXTURES

EXPLAIN:_____

_____

_____

_____

HOW DO YOU ADDRESS THESE BEHAVIOR CONCERNS AT HOME (E.G., DISCIPLINE, CONSEQUENCES, ETC.)?

ARE THERE ANY PAST/PRESENT CIRCUMSTANCES THAT MAY HAVE CONTRIBUTED TO THE STUDENT'S PRESENT DIFFICULTIES (E.G., JOB LOSS, MAJOR ILLNESS, DEATH OF LOVED ONE, COVID-19 PANDEMIC)?

EXPLAIN:

HOW DOES YOUR CHILD SPEND MOST OF HIS/HER TIME? ALONE[ ] WITH YOUNGER CHILDREN[ ]

WITH CHILDREN THE SAME AGE[ ] WITH OLDER CHILDREN[ ] WITH ADULTS[ ]

DOES YOUR CHILD SEE FRIENDS OUTSIDE OF SCHOOL? NO[ ] YES[ ] HOW OFTEN?

WHAT ARE YOUR CHILD'S MAJOR INTERESTS OR HOBBIES?

IN THE SPACE BELOW, PLEASE DESCRIBE YOUR CHILD'S STRENGTHS, YOUR HOPES FOR YOUR CHILD, AND ANY ADDITIONAL COMMENTS:

(ATTACH ADDITIONAL SHEETS IF NECESSARY)

CAREGIVER COMMENTS 1:

NAME OF CAREGIVER 1:

CAREGIVER COMMENTS 2:

NAME OF CAREGIVER 2: _____

IV. <u>OTHER LANGUAGES</u>

(COMPLETE SECTION BELOW <u>ONLY</u> IF A LANGUAGE OTHER THAN ENGLISH IS SPOKEN AT HOME)

HAS YOUR CHILD EVER LIVED OUTSIDE OF THE UNITED STATES? YES[ ] NO[ ]

IF YES, WHERE? _____ FROM WHAT AGE TO WHAT AGE? _____TO _____

HOW LONG HAS YOUR FAMILY LIVED IN THE UNITED STATES? _____

HOW OFTEN DOES YOUR CHILD VISIT HIS/HER HOMELAND? _____

IN WHAT LANGUAGE(S) HAS YOUR CHILD RECEIVED FORMAL SCHOOLING? _____

WHAT LANGUAGE(S) ARE SPOKEN IN YOUR HOME? _____

IN WHAT LANGUAGE(S) DO YOU SPEAK TO YOUR CHILD? _____

IN WHAT LANGUAGE(S) DO OLDER FAMILY MEMBERS USE TO SPEAK TO YOUR CHILD? _____

IN WHAT LANGUAGE(S) DO OTHER CHILDREN USE TO SPEAK TO YOUR CHILD? _____

IN WHAT LANGUAGE DOES YOUR CHILD USE TO SPEAK TO YOU? _____

IN WHAT LANGUAGE DOES YOUR CHILD USE TO SPEAK TO OLDER FAMILY MEMBERS? _____

IN WHAT LANGUAGE DOES YOUR CHILD USE TO SPEAK TO OTHER CHILDREN? _____

WHICH LANGUAGE DID YOUR CHILD LEARN TO SPEAK FIRST? _____

AT WHAT AGE DID YOUR CHILD BEGIN TO LEARN ENGLISH? _____ WHERE? _____

IS YOUR CHILD EXPOSED TO TV, INTERNET, NEWSPAPERS, BOOKS, RELIGIOUS SERVICES, ETC., IN YOUR HOME LANGUAGE ON A REGULAR BASIS? YES[ ] NO[ ]

DO YOU HAVE ANY CONCERNS ABOUT YOUR CHILD'S LANGUAGE ABILITIES? YES[ ] NO[ ]

DO YOU OR OTHER PEOPLE HAVE TROUBLE UNDERSTANDING YOUR CHILD'S SPEECH? YES[ ] NO[ ]

IF YES, EXPLAIN: _____

DOES YOUR CHILD TALK AS WELL AS YOUR OTHER CHILDREN? YES[ ] NO[ ] OTHER CHILDREN HIS/HER SAME AGE? YES[ ] NO[ ]

DOES YOUR CHILD FREQUENTLY USE GESTURE INSTEAD OF SPEECH? YES[ ] NO[ ]

DOES YOUR CHILD HAVE DIFFICULTY ANSWERING QUESTIONS IN ENGLISH OR YOUR HOME LANGUAGE?

YES[ ] NO[ ] IF YES, EXPLAIN: _____

DOES YOUR CHILD HAVE DIFFICULTY FOLLOWING DIRECTIONS IN ENGLISH OR YOUR HOME LANGUAGE?

YES[ ] NO[ ] IF YES, EXPLAIN: _____

DO ANY FAMILY MEMBERS HAVE A HISTORY OF COMMUNICATION DIFFICULTIES? YES[ ] NO[ ]

Thank you for your assistance in completing this form.