____

To the Parents/ Guardians of ____________________________________,

I am submitting your child to the Intervention and Referral Service team (formerly BST) because____. The I & RS is a multidisciplinary team which designs, implements and monitors intervention plans for students experiencing one or more difficulties in the following areas; learning, behavior or health. Enclosed is a parent questionnaire that gives valuable information for the team to review. Please complete the questionnaire and send it back to me as soon as possible. I look forward to building this partnership between school and your family to ensure the best possible educational outcome for your child.

Sincerely,

Parent Questionnaire

Name of student____

Grade________________ Teacher______________________________________

Name of parent/guardian completing this form____

Please check the household in which the student lives

___ Two natural parents

___ Single parent

___ Single parent with stepparent

___ Other, please explain____

Name(s) and relationships of other family living in the household

____

____

Name(s) and relationships of other member(s) living in the household

____

____

Does your child enjoy school?

YES NO

Does your child struggle to do homework?

YES NO

How much time does your child spend doing homework?

a) up to ½ hour b) ½ hr. to 1 hr. c) 1 hr. to 1 ½ hr. d) more than 1 ½ hrs.

Do you do homework with your child?

YES NO

Does your child bring home all the necessary materials to do homework?

YES NO

Do you go through your child's book bag every day?

YES NO

Do you read to your child before bed?

YES NO

Does your child read before bed?

YES NO

Does your child have friends outside of school?

YES NO

Does your child participate in any activities outside of school?

YES NO

If yes, please list activities____

Do you have a good relationship with your child?

YES NO

Does your child have a good relationship with his/her brother(s) and/or sister(s)?

YES NO

Does your child take medication every day?

YES NO

If yes,
What is the name of the medication?______________________________

How much?____________________ How often?______________________

Why does he/she take it?____

Other than what was indicated on the nurse's medical form that you completed in September, are there any other medical conditions we need to know about? (This would include eyeglasses)

____

____

____

Parent/Guardian Signature____

Date______________________________

*****PLEASE RETURN THIS FORM AS SOON AS POSSIBLE TO YOUR CHILD'S CLASSROOM TEACHER*****