



Parent Questionnaire *Please Return to Teacher!*

Please fill out and send back with student as soon as possible.

Student Name: _____ Hand they use (circle one): Left, Right, Ambidextrous

1. Who lives with the student? _____

2. What allergies does the student have? _____

3. Does your child have any medical concerns that I should be aware of? _____

4. What medication does the student take? At Home _____ At School _____

5. Who can I call in the case of an emergency? _____
What is there contact information? _____
Please provide an email address where I can contact you. _____

6. What are your child's strengths? _____

7. What are your child's weaknesses (e.g. areas that may be frustrating or that you feel your child has a particular need to improve)? _____

8. What subject(s) does your child succeed in? _____

9. What subject(s) does your child struggle in? _____

10. What are your academic concerns about your child? _____

11. What are your main hopes for your child this year? _____

12. Eating at school. _____ Breakfast from Cafeteria _____ Lunch from Cafeteria _____ Food by Parents





28. What is the best way to contact you? Please check preferred and if multiple ways please number which you prefer first, second and so on.

_____ in person, _____ email, _____ phone call, _____ messaging through ClassDojo, _____ other _____
(please specify how)

29. Can your name be listed under parent contacts on my classroom webpages? ___ yes ___ no

30. Would you like to volunteer in the class? ___ yes ___ no.

If yes, please provide time and day that's best for you and I will contact you as soon as possible. Also, please present the office with your TB test results prior to making the appointment with me to volunteer.

If yes, please tell me how you'd like to help the classroom:

- _____ in the classroom
- _____ working with students
- _____ making copies

Or

- _____ from home
- _____ take home activities (things that can be done at home and returned back to me in students backpack)
- _____ provide materials to class when needed

31. List 3 Fun Facts about your child – (1). _____
(2). _____
(3). _____

32. What expectations do you have for the team? _____

33. What school services does your child get currently?

- _____ Speech _____ Assistive Technology _____ Adapted Physical Education _____ Occupational Therapy
- _____ Physical Therapy _____ Vision Therapy _____ Hearing Therapy _____ Behavior Intervention
- _____ Counseling _____ One-to-One Support _____ Nurse Support

34. Are you willing to help your child with remote learning? _____ yes _____ no _____ I can't
(Behavior Difficulties)

35. Would you like to meet via remotely once a month for direct support for 20 minutes to discuss concerns, ask for support and address students' academics and behavior? _____ yes or _____ no

If yes please tell me which program you are most comfortable using and would like to use ...

_____ zoom _____ google hangout _____ skype _____ other: please state program _____

If yes please circle the days of the week that work best for you

Monday Tuesday Wednesday Thursday Friday

And the time frame that works best for you

_____ 2:30 -2:50 _____ 2:55-3:15

