AMEDEO COLLEGE

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PARENT QUESTIONNAIRE

PLEASE ATTACH ALL PREVIOUS ASSESSMENT REPORTS AND MOST RECENT SCHOOL REPORT

Date of Submission: _____

DETAILS OF APPLICANT (Child)

PERSONAL INFORMATION

Surname	
Full First Name(s)	
Date of Birth	
ID Number	
Age	
Sex	
Home Language	
Religion	
Present Medication and Dosage	
Street Address	
Postal Address	

MEDICAL AID DETAILS

Medical Aid Name	
Membership Number	
Medical Aid Package	
Dependent Code	
Medical Aid Contact Number	

Directors:
Dougie van der Westhuizen
Lindie van der Westhuizen

23 De La Rey Road, Rivonia
Sandton, 2129, Johannesburg
Tel: 010 500 3230

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SCHOOL HISTORY

Name of Current School	
School Telephone Number	
Principal Name	
Class Teacher Name	
Teacher Telephone Number	
Teacher E-mail address	
Present Grade	
Grade's Repeated	
Medium of Instruction	

How many children are in his/her class? / Does your child relate well to his/her teacher? / Are you happy with the attention he receives?

_____

_____

_____

OTHER SCHOOLS ATTENDED

	Name	Month & Year ofEntry	Child's Age	Month and Year ofExit
Créche				
NurserySchool				
PrimarySchool				

Was a Readiness Assessment conducted? Yes ☐ No ☐

If the child was considered not ready, what reasons were given? _____

_____

In which Grade were difficulties first noticed? _____-_____

_____

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PARENT INFORMATION	FATHER	MOTHER
Full Name		
ID Number		
Present Occupation		
Nationality		
Name of Business		
Business Address		
Business Telephone Number		
Cellphone Number		
Home Telephone Number		
E-mail Address		
Residential Address		
Postal Address		
Previous occupations over child's lifespan		
Have any of these jobs necessitated long absences from home		

MARITAL STATUS: Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Deceased ☐

If separated, to whom must documentation be sent? Both ☐ Father Only ☐ Mother Only ☐

If divorced, who has legal custody? Father ☐ Mother ☐

If divorced, does the other parent have access and visiting rights? Yes ☐ No ☐

Is the child: Biological ☐ Fostered ☐ Adopted ☐

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Siblings (In Chronological Age):

Name	Age	School	Class	Academic progress

Position of child within the family: _____

HOW DO YOU VIEW YOUR CHILD?

IT IS VERY IMPORTANT THAT EACH PARENT FILL IN THIS SECTION SEPARATELY AS IT CONTAINS VALUABLE INFORMATION

FATHER'S DESCRIPTION

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MOTHER'S DESCRIPTION

OTHER SIGNIFICANT PERSON'S DESCRIPTION (AU PAIR ETC)

YOUR CHILD NOW (AT HOME)

(Please tick the box which most applies to your child)

SLEEP: Restless ☐ Regular ☐ Nightmares ☐ Bedwetting ☐ Sleepwalking ☐

HABITS: Thumb sucking ☐ Nail biting ☐ Twitching ☐ Other_____

Can your child concentrate for an extended period? (E.g. Playing, watching TV) Yes ☐ No ☐

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Do you continually repeat instructions? Yes ☐ No ☐

Does your child get distracted easily? Yes ☐ No ☐

RATE THE FOLLOWING:

Concentration	Good ☐	Average ☐	Poor ☐
Activity Level	Good ☐	Average ☐	Poor ☐
Talks	Good ☐	Average ☐	Poor ☐
Fidgets	Good ☐	Average ☐	Poor ☐

YOUR CHILD SOCIALLY (at home)

Does he/she prefer to be alone? Yes ☐ No ☐

Does he/she like to have the company of friends? Yes ☐ No ☐

Does he/she interact well with friends? Yes ☐ No ☐

What age group does he/she prefer to spend time with? Older ☐ Younger ☐ Both ☐

How does he/she interact with family members? _____

_____

How does he/she interact with other adults? _____

_____

PRESENT CONCERNS/EDUCATIONAL PREFERENCES

Please state person and/or organisation who made the referral: (e.g. school, doctor, teacher, family, friend or other)

_____

Please state your reason for seeking Individualised Education

_____

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Please give details of your concerns. What do you think are the reasons for these problems and what arethe contributing factors?

_____

_____

_____

_____

Is your child left-handed? Yes ☐ No ☐

Is any other family? Yes ☐ No ☐ Relationship: _____

Has the child or the family ever experienced any trauma?
e.g. Death of a loved one, divorce, hijacking, violence etc. Please provide details

_____

_____

_____

_____

DISCIPLINE

Who disciplines at home and how?

_____

_____

_____

Is it consistent? Yes ☐ No ☐

What discipline problems do you experience with your child?

_____

_____

_____

_____

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PREVIOUS ASSESSMENTS

Please state whether your child has had any previous testing (e.g. psychological, educational) and if so, by whom and when?

DOCTOR

Name and Surname	
Contact Number	
Reason	
Assessment Date	
Findings	
Medication	

NEUROLOGIST

Name and Surname	
Contact Number	
Reason	
Assessment Date	
Findings	
Medication	

PSYCHOLOGIST/PSYCHIATRIST

Name and Surname	
Contact Number	
Reason	
Assessment Date	
Findings	
Medication	

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OCCUPATIONAL THERAPIST

Name and Surname	
Contact Number	
Reason	
Assessment Date	
Findings	
Medication	

SPEECH THERAPIST

Name and Surname	
Contact Number	
Reason	
Assessment Date	
Findings	
Medication	

PHYSIOTHERAPIST

Name and Surname	
Contact Number	
Reason	
Assessment Date	
Findings	
Medication	

REMEDIAL THERAPIST

Name and Surname	
Contact Number	
Reason	
Assessment Date	
Findings	
Medication	

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SCHOOL THERAPIST

Name and Surname	
Contact Number	
Reason	
Assessment Date	
Findings	
Medication	

SCHOOL PSYCHOLOGIST

Name and Surname	
Contact Number	
Reason	
Assessment Date	
Findings	
Medication	

CURRENT THERAPY

IF YOUR CHILD IS STILL RECEIVING THERAPY, PLEASE ASK THE THERAPIST FOR A RECENT PROGRESS REPORT

PLEASE INCLUDE ALL THERAPY YOUR CHILD HAS RECEIVED

Has your child had a thorough examination recently by a doctor? Yes ☐ No ☐

If so, please specify the following: Doctors Name: _____

Date: _____

Findings: _____

Year	Type of medication and dosage	Prescribed by	Behavioural changes

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DECLARATION

I,_____, herby confirm that all information provided is true and correct, in capacity of parent or guardian.

SIGNED: _____

If other please specify, _____

DATE: _____

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