**EDUCATIONAL SERVICE UNIT NO. 11**
412 W. 14TH AVE. • P.O. BOX 858
HOLDREGE, NE 68949-0858

TELEPHONE (308) 995-6585 • FAX (308) 995-6587
WWW.ESU11.ORG

# PARENT INPUT FORM

Student's Name:________________________________________ Age:________ Grade:______________

Date of Birth:__________________ Parent/Guardian:__________________________________________

Date(s) teacher talked to Parent/Guardian regarding this concern:______________________________________

Academics:

Strengths:_______________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________

Concerns:________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________

Speech/Language:

Strengths:_______________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________

Concerns:________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________

Behavior/Attention:

Strengths:_______________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________

Concerns:________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________

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## PARENT INPUT FORM CONTINUED…

Social Skills:

Strengths:_______________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

Concerns:_______________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

Possible motivators—Interests or Hobbies:
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

Have there been any accidents such as falls, or head injuries? ___ Yes___ No

Have you talked with your physician about any concerns? ___ Yes___ No

Is your child taking medication?

___ No

___ Yes

- Name of Physician:______________________ Phone:_______________

1. Medication:_____________________________ How Often:__________
   Side Effects:_______________________________________________

2. Medication:_____________________________ How Often:___________
   Side Effects:_________________________________________________

3. Medication:_____________________________ How Often:____________
   Side Effects:_________________________________________________

Any history of head trauma, brain bleed, oxygen deprivation, high fever, brain infections (meningitis, encephalitis, etc.) ___ Yes ___ No

***Please return to _____________________________________by__________________. Thank you!***