STUDENT HISTORY FORM
3 YEAR OLD PROGRAMME

Child' Name ________________________________ **Date of Birth** ______________

Please complete all the sections relevant to your child by ticking the relevant boxes

Speech and Language

Have you noticed any unusual speech patterns? Yes ❑ No ❑

Articulations Difficulties ❑ Late talking ❑ Stuttering ❑

Is there a family history of speech and language or reading and writing difficulties? Yes ❑ No ❑

Does your child speak any other language other than English in the home? Yes ❑ No ❑

If yes, the language is ________________________________

Hearing

Between 12 and 36 months in particular

Has your child had recurring ear infections? Yes ❑ No ❑

Has your child had Glue Ear? Yes ❑ No ❑ Grommets? Yes ❑ No ❑

Milestones

Did your child experience any delays in gaining milestones? Yes ❑ No ❑

Eg. Learing to roll, crawl, sit, stand or walk?

Vision

Has your child had any visual problems? Yes ❑ No ❑

Has your child had or do they have a lazy eye? Yes ❑ No ❑

Have they worn / do they wear glasses? Yes ❑ No ❑

General Health

Has your child had serious health problems? Yes ❑ No ❑

Emotional Health

Any notable family circumstances in the child's early years? Yes ❑ No ❑

eg. Loss in family

Has your child been seen by any of the following: Yes ❑ No ❑

Paediatrician (excluding the normal "at birth visit")

Speech therapist Yes ❑ No ❑ Audiologist Yes ❑ No ❑

Occupational Therapist Yes ❑ No ❑ Physiotherapist Yes ❑ No ❑

Other: ____

Is there any other relevant information that the school should be aware of that may impact on your child's education Yes ❑ No ❑

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