

Instruction - Exhibit - Programs for Migrant Students
Family Interview Form

To be completed by Building Principal or designee: (please print)

Child 1 Name	Birth Date	Grade	School Dist / Bldg
Child 2 Name	Birth Date	Grade	School Dist / Bldg
Child 3 Name	Birth Date	Grade	School Dist / Bldg

Name of Parent/Guardian	Language(s)
Telephone Number or other contact information	Today's Date

Needs Assessment

Please circle or check response

1. Do any of your children have health problems that interfere with their ability to learn?	YES	NO	Explain:	
2. In what areas might your child(ren) need additional help in school?	Reading	Math	Language	Other (Specify)
Child 1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Child 2	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Child 3	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
3. Are your child(ren)'s immunizations up to date?	YES	NO	Don't know	
4. Do you have immunization records?	YES	NO	Don't know	
5. Have you established a source of primary healthcare?	YES	NO		

Resources and Referrals

1. Would you be interested in information on:	<i>(please circle)</i>		
Head Start	YES	NO	Already Enrolled

District Preschool	YES	NO	Already Enrolled
Parents as Teachers	YES	NO	Already Enrolled
GED/ESL Classes	YES	NO	Already Enrolled

2. Would you be interested in information on:

Public/County Health Dept.	YES	NO	
Division of Family Services	YES	NO	Welcome Pack Given?

3. May we share your name and address with these agencies? YES NO

4. When is the best time to reach you at home? AM PM Days of the week:
 ___:___ ___:___ Mo Tu We Th Fr

Name of Person Completing Form

Name of Person Being Interviewed and His/Her Relationship to Family/Children

LEGAL REF.:

CROSS REF.:

APPROVED: 8/17/2005

REVISED: