SPD Study Screening (13/IRB/074) **Dx**_____

Child's name:	**Name of school & district:**
Child's Date of birth: / /	**Child's gender:** □ Male □ Female
Parent/Guardian's name:	**Relationship with child:**
If <u>not</u> natural parent, how long has the child been living with you? _____**years**	
Home: ( ) -	**Cell: ( ) -**
Email:	**Preferred:** : □ Email □ Text □ Phone

Do you have paperwork/documents from school/therapist? □ Yes □ No

Has your child ever been seriously ill? (Other than cold or flu) □ Yes □ No

If yes, please explain:

General medical conditions:

Does your child have any of the following:

Blindness	□ Yes □ No	**Broken Bone(s) in past 6 months**	□ Yes □ No
Deafness	□ Yes □ No	**Previous head injury**	□ Yes □ No
Scoliosis	□ Yes □ No	**Cerebral Palsy**	□ Yes □ No

Does your child use anything to help him/her walk (ex: crutches/walker)? □ Yes □ No

Does your child have any eye problems that are not corrected by glasses? □ Yes □ No

If yes, please explain:

Does your child receive vision therapy? Read letters & numbers? □ Yes □ No

When was the last vision exam? *(month/yr)* /	□ **School** □ **Pediatrician** □ **Eye specialist**

This study involves your child going through five stations, which takes about 1 ½ - 2 hours. Do you think your child would be able to follow verbal directions without assistance? □ Yes □ No

Are you interested in participating in this research project? □ Yes □ No

If yes, are you available weekday evenings or Saturdays: *(Weekday PM = 5-8PM; Sat AM 9-12; Sat PM = 1-4)*

□ Mon PM □ Tues PM □ Thurs PM □ Sat AM □ Sat PM

What time of day is most convenient to call:

□ Morning □ Midday/Afternoon □ Evening

How did you hear about this study?