

Notes on filling out this form:

Please fill in or mark with a cross ☒

Answering all or just individual questions is voluntary!

Child's family name	Child's first name	Born on	Nationality	Number of siblings
Native language (mother)	Native language (father)	Number of adults in the household	Has been attending crèche/daycare/kindergarten for <input type="text"/> years	
Name and address of parent or legal guardian <i>Family name(s).....First name(s)..... Postcode/town.....</i> <i>Street.....Tel. no.....</i>				
Pregnancy and birth				
Birth weight: _ _ _ _ grams Completed pregnancy weeks: _ _ PWs <input type="checkbox"/> Multiple birth				
Development				
Has any delayed development <u>ever</u> been determined in your child?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
Unassisted walking by 18 months			<input type="checkbox"/> Yes	<input type="checkbox"/> No
First words (such as <i>mum, dad, car</i>) by 18 months			<input type="checkbox"/> Yes	<input type="checkbox"/> No
Speech disorder during development			<input type="checkbox"/> Yes	<input type="checkbox"/> No
Child grows up multilingual			<input type="checkbox"/> Yes	<input type="checkbox"/> No
Which languages do you speak at home?				
<input type="checkbox"/> German <input type="checkbox"/> Other language(s) (which): _____				
In contact with the German language			<input type="checkbox"/> from birth <input type="checkbox"/> not from birth	
If not in contact with the German language from birth, from which age? _ _ Years _ _ months				
Is your child <input type="checkbox"/> right-handed <input type="checkbox"/> left-handed <input type="checkbox"/> still undecided				
Does your child have or has your child had one of the following illnesses or health impairments?				
Has your child ever been examined by an eye specialist?			<input type="checkbox"/> No	<input type="checkbox"/> Yes
If Yes, please answer the following questions:				
▶ Were drops used for pupil dilation?			<input type="checkbox"/> No	<input type="checkbox"/> Yes
▶ Was a visual impairment determined?			<input type="checkbox"/> No	<input type="checkbox"/> Yes
↳ If Yes, what treatment was performed?				
▶ Glasses			<input type="checkbox"/> No	<input type="checkbox"/> Yes
▶ Eye patch/training			<input type="checkbox"/> No	<input type="checkbox"/> Yes
▶ Strabismus operation			<input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Planned
Serious congenital hearing disorder			<input type="checkbox"/> No	<input type="checkbox"/> Yes
If Yes, please answer the following questions:				
Congenital hearing disorder		<input type="checkbox"/> Left ear	<input type="checkbox"/> Right ear	<input type="checkbox"/> Both sides
Wears hearing aid		<input type="checkbox"/> Left ear	<input type="checkbox"/> Right ear	<input type="checkbox"/> Both sides
Wears cochlear implant		<input type="checkbox"/> Left ear	<input type="checkbox"/> Right ear	<input type="checkbox"/> Both sides

Please turn over!

Metabolic or hormone disorders: No Yes

If Yes, which? MCAD deficiency Hypothyroidism (congenital) PKU CAH

Cystic fibrosis Diabetes mellitus (type 1) Diabetes mellitus (type 2)

Other:

Age at diagnosis: |_|_| | |_|_|_|
 Years Months

Other chronic illnesses: No Yes (which?):

Severe handicap: No Yes (which?):

Must take medication regularly: No Yes (which?):

Are you aware of illnesses your child may have that require specific procedures in emergency situations (e.g., allergies, epilepsy, etc.)? No Yes

If Yes, which?

Pediatrician/family doctor:

.....

.....

Has your child ever had any of the following assistance measures or treatments?

- | | | | |
|--------------------------------------|-----------------------------|------------------------------------|---|
| Participation in German prep classes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Planned |
| Speech therapy (logopedics) | <input type="checkbox"/> No | <input type="checkbox"/> Completed | <input type="checkbox"/> Ongoing <input type="checkbox"/> Planned |
| Physiotherapy | <input type="checkbox"/> No | <input type="checkbox"/> Completed | <input type="checkbox"/> Ongoing <input type="checkbox"/> Planned |
| Remedial education | <input type="checkbox"/> No | <input type="checkbox"/> Completed | <input type="checkbox"/> Ongoing <input type="checkbox"/> Planned |
| Orthopaedagogy | <input type="checkbox"/> No | <input type="checkbox"/> Completed | <input type="checkbox"/> Ongoing <input type="checkbox"/> Planned |
| Ergotherapy | <input type="checkbox"/> No | <input type="checkbox"/> Completed | <input type="checkbox"/> Ongoing <input type="checkbox"/> Planned |

- How often does your child see the dentist? At least once a year for check-up
- Less than once a year for check-up
- Only when they have a complaint
- My child has never been to the dentist

Would you say that, on the whole, your child has difficulties in one or more of the following areas: Voice (despondent, anxious, wavering, explosive), concentration (cannot sit still for long, doesn't listen consistently when being read to), behavior, interaction with others?

No Yes

Are there any of the following in the family (parents, siblings)

- | | | |
|--|-----------------------------|------------------------------|
| ▶ Reading-writing difficulty (dyslexia)? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| ▶ Difficulty calculating (dyscalculia) | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| ▶ Strabismus | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| ▶ Severe longsightedness (>3dpt), astigmatism >3dpt, shortsightedness >10dpt | <input type="checkbox"/> No | <input type="checkbox"/> Yes |

Date of completion:

Data privacy policy according to the new General Data Protection Regulation

<https://www.landratsamt-dachau.de/dsgvo/schuleingangsuntersuchung>