CHILD INTERVIEW

Eastern Illinois
Area of Special
Education
Phone: 217/348-7700
FAX: 217/348-7704

Date Form Completed: _____

STUDENT NAME		BIRTHDATE	SEX	AGE
RESIDENT DISTRICT	ATTENDANCE DISTRICT	BUILDING NAME		GRADE
COMPLETED BY: NAME/POSITION				

SCHOOL (be sure to include the child's perception of the reason for the referral, the student's attitude toward school and school rules, how the student gets along with the teachers and what subjects the student likes and dislikes.)

HOME (include any comments about the student's home life that relates to school performance.)

COMMUNITY (include the student's perception of peer relationships.)