

Programs for Migrant Students – Family Interview Form
To be completed by Building Principal or designee: (please print)

Child Name	Birth Date	Grade	School
Name of Parent/Guardian		Language(s)	
Telephone Number or other Contact Information		Today's Date	

Needs Assessment

Please Check Response

1. Do any of your children have health problems that interfere with their ability to learn? Explain: Yes No
-
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"/> | <input type="checkbox"/> _____ |
| Child 2 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> _____ |
| Child 3 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> _____ |
3. Are your child's(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 Don't know
 If not, would you be interested in information on primary healthcare? Yes No Don't know

Resources and Referrals

Please Check Response

1. Would you be interested in information on:
 Public/County Health Dept. Yes No
 Division of Family Services Yes No
2. May we share your name and address with these agencies? Yes No
3. When is the best time to reach you at home?
 AM PM
 Days of the week:
 Monday Tuesday Wednesday Thursday Friday

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