

Parent Transition Interview

PERSONAL DATA

Child's Name:	<input style="width: 95%;" type="text"/>	Date:	<input style="width: 95%;" type="text"/>
Address:	<input style="width: 95%;" type="text"/>	City:	<input style="width: 95%;" type="text"/>
Phone:	<input style="width: 95%;" type="text"/>	Date of Birth:	<input style="width: 95%;" type="text"/>
Parent/Guardian:	<input style="width: 95%;" type="text"/>	Grade in School:	<input style="width: 95%;" type="text"/>

1. What year does your child plan to graduate? _____
2. Please check hobbies or special interests of your child:

<input type="checkbox"/> arts and/or crafts	<input type="checkbox"/> bicycling	<input type="checkbox"/> boating	<input type="checkbox"/> camping
<input type="checkbox"/> collections	<input type="checkbox"/> fishing	<input type="checkbox"/> hiking	<input type="checkbox"/> hunting
<input type="checkbox"/> music	<input type="checkbox"/> jog or walk	<input type="checkbox"/> reading	<input type="checkbox"/> work on engines
<input type="checkbox"/> video games	<input type="checkbox"/> skating	<input type="checkbox"/> skiing	<input type="checkbox"/> watching TV
<input type="checkbox"/> computer	<input type="checkbox"/> other (<i>specify</i>): _____		
3. Please check community participation options for your child:

<input type="checkbox"/> participate in clubs, church groups	<input type="checkbox"/> go dancing	<input type="checkbox"/> register to vote
<input type="checkbox"/> recreational facilities (<i>skating, bowling, swimming</i>)	<input type="checkbox"/> drive around	<input type="checkbox"/> selective service
<input type="checkbox"/> participate in individual or team sports	<input type="checkbox"/> eat out	<input type="checkbox"/> socialize with friends/date
<input type="checkbox"/> YMCA / fitness center	<input type="checkbox"/> go shopping	
<input type="checkbox"/> watch sporting events	<input type="checkbox"/> go to movies	
4. What kind of high school programs do you think are important in preparing your child to meet his/her plans after high school?
 - classes which prepare for college
 - classes which teach functional academics (*budgeting, checking, income tax, etc.*)
 - classes which teach skills needed for independent living (*cooking, shopping, social skills, child care, etc.*)
 - classes which teach vocational skills (*business, mechanics, carpentry, welding, computers, agriculture, CAD, tech lab, etc.*)
 - classes which teach fine/performing arts (*music, art, drama. etc.*)
 - classes which teach physical education
 - health care
 - work study (*job training in the school/community*)
 - foreign language
5. Transportation Issues

Does your child have a driver's license?	YES	NO
If not, does he/she plan to get one?	YES	NO
How? _____	When? _____	
Does your child need assistance in getting one?	YES	NO
Does your child own a vehicle?	YES	NO

If your child is not planning to get a driver's license what type of transportation will he/she use?

- walking riding a bike community or public transportation
 car pool other (specify): _____

Will your child need help with transportation? YES NO

6. Money

- Can your child count back change? YES NO
Does your child have a savings account? YES NO
Does your child have a checking account? YES NO
Can your child balance a checkbook? YES NO
Does your child routinely save money for major purchases? YES NO
Does your child know how to compare prices for the best buy? YES NO
Can your child budget his/her money to make it last from one pay period to the next? YES NO
Has your child borrowed money? YES NO

7. Does your child currently receive:

- Supplementary Security Income (SSI) YES NO
Aid to Dependent Children YES NO
Disability Income (SSDI) YES NO
Survivor Benefits YES NO
Medical Card YES NO
Other (specify): _____

8. Does your child receive services from other agencies?

- Court Services DSGP JJA KRS
 MCDS Prairie View SRS Other: _____

Are there agencies you would like information on? _____

POST HIGH SCHOOL PLANS

1. What is your child planning to do after high school?

- work junior college Job Corp
 four year college military service Vo-Tech School
 sheltered workshop apprenticeship other (specify): _____

Will your child need assistance getting connected with the program her/she wants after high school? YES NO

Will your child want assistance from Kansas Rehabilitation Services? YES NO

2. Where does your child want to live after high school?

- at home with parent/guardian live alone
 with relatives share an apartment/house
 dormitory group home
 supervised apartment other (specify): _____

3. What type of leisure/community activities does your child plan to do?

- religious services/programs family outings
 outdoor activities (camp, fish, hunt) family events
 sports care for pet
 lessons (music, art, dance, etc.) pursue a hobby
 library play board games
 clubs other (specify): _____

4. Will your child have health insurance after you leave high school? YES NO

5. Will your child be making decisions on his/her own or need some assistance?

- checkbox on own checkbox need assistance

Does your child need information on how to get help for making decisions (guardianship)?

YES NO

WORK EXPERIENCE

1. What chores does your child do around the house at least once a week or as needed?

- checkbox make own bed checkbox dust checkbox wash and/or dry dishes
checkbox clean own room checkbox vacuum checkbox load and/or unload dishwasher
checkbox clean other rooms checkbox take out trash checkbox cook
checkbox do laundry checkbox mow lawn checkbox buy groceries
checkbox iron checkbox scoop snow checkbox put away groceries
checkbox babysit checkbox rake leaves checkbox clean vehicles
checkbox take care of pet checkbox pick weeds checkbox clean garage
checkbox other (specify): _____

How responsible is your child in doing these chores?

- checkbox needs no reminders checkbox needs two or three reminders
checkbox needs one reminder checkbox needs more than three reminders
checkbox other (specify): _____

2. Volunteer experiences

- checkbox none checkbox church work checkbox work with children
checkbox concession stand checkbox team manager checkbox work with elderly
checkbox serve on committees checkbox work in hospital checkbox work with people with disabilities
checkbox other (specify): _____

3. Paid jobs

- checkbox mowing lawns checkbox shoveling snow checkbox babysitting checkbox paper route
checkbox concession stand checkbox errands checkbox pet care
checkbox other (specify): _____

4. Is your child presently employed? YES NO

If yes, does your child work:

- checkbox week days checkbox week nights checkbox weekends checkbox combination

5. If your child is presently employed, who found the job?

- checkbox student checkbox friend checkbox parent/guardian
checkbox school employee checkbox other relative checkbox other (specify): _____

Table with 5 columns: Work Experience, Type of Work, From, To, Reason for Leaving. Includes three rows of blank lines for data entry.

Has your child ever filled out a job application form?	YES	NO
Did anyone help your child fill out the form?	YES	NO
Does your child need help with application forms?	YES	NO
Has your child ever had an interview for a job?	YES	NO
Did your child have any problems at the interview?	YES	NO
Does your child need help with job interviews?	YES	NO

CAREER INTERESTS:

1. What kind of job/careers is your child interested in?

first choice	second choice	third choice
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2. What jobs/career would your child like to know more about?

3. What jobs/careers would your child like to avoid?

4. What is your child's favorite tech lab module? _____

5. Preferred working conditions:

- | | | | |
|--|---------------------------------------|---------------------------------------|---|
| <input type="checkbox"/> indoors | <input type="checkbox"/> with people | <input type="checkbox"/> quiet place | <input type="checkbox"/> moving around |
| <input type="checkbox"/> outdoors | <input type="checkbox"/> with things | <input type="checkbox"/> busy | <input type="checkbox"/> sitting/standing still |
| <input type="checkbox"/> wear casual clothes | <input type="checkbox"/> with ideas | <input type="checkbox"/> dirty | <input type="checkbox"/> some sitting/moving |
| <input type="checkbox"/> wear dress clothes | <input type="checkbox"/> with animals | <input type="checkbox"/> neat / clean | <input type="checkbox"/> same task |
| <input type="checkbox"/> wear uniforms | <input type="checkbox"/> day time | <input type="checkbox"/> supervised | <input type="checkbox"/> different task |
| <input type="checkbox"/> one place | <input type="checkbox"/> night time | <input type="checkbox"/> unsupervised | |
| <input type="checkbox"/> travel | | | |

HEALTH HISTORY

Does your child have a doctor he/she see on a regular basis? YES NO

Has your child used the County Health Office? YES NO

PHYSICAL SKILLS

Vision

Does your child have difficulties with close work? YES NO

Does your child have difficulties with distance? YES NO

Does your child have difficulties with tracking? YES NO

Does your child wear glasses or contact lens? YES NO

Please explain any of the above you answered yes to or other vision problems. _____

Hearing

Does your child have any difficulties hearing in a noisy environment YES NO

If yes, please explain: _____

Is hearing protection required/recommended? YES NO

Are hearing aids or other devices recommended/used? YES NO

Speech

What is your child's primary form of communication?

- oral
- sign
- written
- communication board

Ease of understanding

- easily understood by all
- understood most of the time by all
- understood by family only
- other: _____

Physical Endurance

Does your child have difficulty with:

- walking
- stooping
- carrying
- grasping
- running
- jumping
- bending
- lifting
- other: _____

What aids does your child require for mobility?

- none
- wheelchair
- cane
- dog
- attendant
- poles
- walker
- other: _____

Please explain any restrictions your child has for participating in physical activities.

Physical Needs/Exceptionalities

Does your child have:

- asthma
- colostomy
- epilepsy
- arthritis
- diabetes
- cerebral palsy
- prosthesis
- other: _____

Is your child allergic to:

- dust
- plants
- foods
- cleaners
- animals
- molds
- other: _____

Is your child sensitive to heat?

YES NO

Is your child sensitive to cold?

YES NO

Please explain: _____

Medications

What medications does your child take on a regular basis?

Side effects of medications: _____

Limitations due to medications: _____

Discuss other health issues which are important to "life after high school". _____
