

# Parent Transition Interview

## PERSONAL DATA

Child's Name: <input style="width: 90%;" type="text"/>	Date: <input style="width: 90%;" type="text"/>
Address: <input style="width: 90%;" type="text"/>	City: <input style="width: 90%;" type="text"/>
Phone: <input style="width: 90%;" type="text"/>	Date of Birth: <input style="width: 90%;" type="text"/>
Parent/Guardian: <input style="width: 90%;" type="text"/>	Grade in School: <input style="width: 90%;" 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?

on own  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?

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

How responsible is your child in doing these chores?

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

2. Volunteer experiences

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

3. Paid jobs

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

4. Is your child presently employed? YES NO

If yes, does your child work:

- week days  week nights  weekends  combination

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

- student  friend  parent/guardian
- school employee  other relative  other (specify): \_\_\_\_\_

Work Experience	Type of Work	From	To	Reason for Leaving
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

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

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.

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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?

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Side effects of medications: \_\_\_\_\_

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Limitations due to medications: \_\_\_\_\_

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

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