PARENTAL/GUARDIAN IN-PUT FOR EVALUATION

Dear _____ ,

We would appreciate your assistance in collecting information about your child as we begin the evaluation process. Feel free to add any additional information or comments that you feel are important. **Please return this form and the signed Consent for Evaluation form to _____.**

Student's Social Security Number _____

Student's Last Name _____   Student's First Name _____

Birth Date: _____   M/F _____   School District Attending _____

Parent/Guardian Name _____   Home Phone _____

Address _____   City/Zip _____

Child is presently living with:

☐ Biological Mother   ☐ Stepmother   ☐ Adoptive Mother   ☐ Foster Mother
☐ Biological Father   ☐ Stepfather   ☐ Adoptive Father   ☐ Foster Father

Other (Specify): _____   Language Spoken in the Home: _____

Best time(s) to contact parent/guardian by phone: _____

FAMILY

Mother's Name: _____

Occupation: _____   Work Telephone Number: _____

School: Highest grade completed _____

Special Assistance in School? (ex.: tutoring, etc.) _____

Medical/Emotional Concerns: _____

Father's Name: _____

Occupation: _____   Work Telephone Number: _____

School: Highest grade completed _____

Special Assistance in School? (ex.: tutoring, etc.) _____

Medical/Emotional Concerns: _____

LIST STUDENT'S BROTHERS AND/OR SISTERS

	Name	Age	Medical/Social/School Concerns
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____

PREGNANCY – Were there any complications during pregnancy with this child? _____

_____

_____

_____

_____

CHILD'S MEDICAL HISTORY

Please list the incident or illness along with the date it occurred.

☐ Childhood Diseases:
_____
_____
_____

☐ Persistent High Fever:
_____
_____
_____

☐ Hospitalizations for Illness:
_____
_____
_____

☐ Eye Problems:
    Wears glasses or contact lenses: ☐ yes ☐ no
_____
_____

☐ Operations:
_____
_____
_____

☐ Tics: (i.e. blinking,, sniffing, etc.)
_____
_____
_____

☐ Head Injuries:
_____
_____
_____

☐ Ear Problems: (i.e. ear infections)
_____
_____
_____

☐ Convulsions:
    ☐ with fever   ☐ without fever
_____   _____
_____   _____

☐ Allergies or Asthma:
_____
_____
_____

☐ Coma:
_____
_____
_____

Please indicate any diagnosed conditions:

☐ ADHD   ☐ Depression   ☐ Anxiety
☐ Autism   ☐ Aspergers   ☐ ODD
☐ Other_____

Pease list any medications your child is taking on an on-going basis:

☐ _____
☐ _____
☐ _____

SCHOOL HISTORY

Previous School Districts Attended:
☐ _____
☐ _____
☐ _____

Special Services Received:
_____
_____
_____

If you have any questions or need assistance in completing this form, please call

_____ at _____

Thank you for your assistance.

_____   _____
District/Cooperative Staff   Date