



**EMERGENCY / PICK-UP INFORMATION (other than parent or guardian)**

Name	Relationship	Home/Work Phone	Cell Phone
Physician to Notify in Case of Emergency :			Tel.

**SCHOOL HISTORY**

Preschool:     Home with Parent or Guardian                       Day Care                       Pre-K Program

Schools Attended (starting with most recent):

Grade	School	Address	Phone #

**GENERAL STUDENT INFORMATION**

Has the Student...

Had scholastic difficulties in school?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Been retained? If yes, in what grade(s)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Participated in Special Ed classes or undergone special academic and/or psychological testing?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Taking or taken medication for academic purposes?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Had disciplinary difficulty in school?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Been suspended or expelled from school?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Been asked to permanently leave a school?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Been diagnosed as having emotional difficulties?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Been diagnosed as having a physical disability?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you know of any factors that may interfere with your child's learning?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Please explain or clarify any "Yes" answers (use an extra sheet of paper if needed).

If your child is being treated for any special medical, emotional, or learning needs, please list the persons(s) responsible for treatment (doctor, psychologist, etc.) and their telephone number.

