

Student Information Sheet

Name of Student: _____ **Birthdate:** _____
Grade: _____
Address: _____
City: _____ **State:** _____ **Zip Code:** _____
Student lives with: _____

Mothers Name: _____
Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____
Address: _____
Email Address: _____

Fathers Name: _____
Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____
Address: _____
Email Address: _____

Disability: Check all that apply to your child.

- | | | |
|---|---|---|
| <input type="radio"/> Multiple Sclerosis | <input type="radio"/> Speech & Language Disability | <input type="radio"/> Conduct Disorder |
| <input type="radio"/> Parkinson's Disease | <input type="radio"/> Fetal Alcohol Syndrome | <input type="radio"/> Sensory Integration Dysfunction |
| <input type="radio"/> Cerebral Palsy | <input type="radio"/> Anxiety Disorder | <input type="radio"/> Tourette Syndrome |
| <input type="radio"/> Muscular Dystrophy | <input type="radio"/> Depression | <input type="radio"/> Aphasia/Dysphasia |
| <input type="radio"/> Spina Bifida | <input type="radio"/> Bipolar Disorder | <input type="radio"/> Apraxia/Dyspraxia |
| <input type="radio"/> Cancer _____ | <input type="radio"/> Obsessive Compulsive Disorder | <input type="radio"/> Auditory Processing |
| <input type="radio"/> Cystic Fibrosis | <input type="radio"/> Schizophrenia | <input type="radio"/> Dyslexia |
| <input type="radio"/> Tuberculosis | <input type="radio"/> Neurosis | <input type="radio"/> Dyscalculia |
| <input type="radio"/> Diabetes | <input type="radio"/> Autism | <input type="radio"/> Dysgraphia |
| <input type="radio"/> Spinal Cord Injury | <input type="radio"/> Asperger's Syndrome | <input type="radio"/> Visual Processing |
| <input type="radio"/> Traumatic Brain Injury | <input type="radio"/> ADD/ADHD | <input type="radio"/> Memory Disabilities |
| <input type="radio"/> Hearing Impaired | <input type="radio"/> Mental Retardation | <input type="radio"/> Nonverbal Learning Disorder |
| <input type="radio"/> Visually Impaired | <input type="radio"/> Down Syndrome | <input type="radio"/> Other: _____ |
| <input type="radio"/> Seizure Disorder/Epilepsy | <input type="radio"/> Oppositional Defiant Disorder | <input type="radio"/> None |

Does your child have a current 504 plan or IEP? Yes No Date of last IEP? _____

Medical Information

Does your child use any of the following: (Answer each item and provide additional comments on the space provided.)

Hearing Aid / Cochlear Implant	Yes	No	_____
Corrective Eyewear	Yes	No	_____
Orthopedic or Prosthetic Devices	Yes	No	_____
Manual Wheelchair	Yes	No	_____
Stroller	Yes	No	_____
Walker	Yes	No	_____
Cane	Yes	No	_____
Canadian Crutches	Yes	No	_____
Computer or other device	Yes	No	_____
Computer software	Yes	No	_____

Student Information Sheet (Page 2)

Name of Student: _____

Does your child have any allergies? _____

Does your child have any food restrictions? _____

Does your child have any sleeping difficulties or disabilities? _____

Does your child require more bathroom or drinking breaks during the school day? (If so, please explain) _____

Does your child require assistance with any of the following? (Answer each item and provide comments on the space provided.)

Eating / drinking	Yes	No	_____
Toileting	Yes	No	_____
Dressing / Undressing	Yes	No	_____
Safety Needs	Yes	No	_____
Communication	Yes	No	_____

Medications

Is your child currently taking any medications? (If so, please explain) _____

Will your child be receiving any of these medications during the school day? Yes No

Please list medication and time of day it will be taken at school? _____

Does your child work with any of the following professionals outside of school? (Please check all that apply)

- | | | |
|--|--|--|
| <input type="radio"/> Tutor | <input type="radio"/> Occupational Therapist | <input type="radio"/> Physical Therapist |
| <input type="radio"/> Speech Therapist | <input type="radio"/> Psychologist | <input type="radio"/> Psychiatrist |
| <input type="radio"/> Counselor | <input type="radio"/> Social Worker | <input type="radio"/> Educational Consultant |
| <input type="radio"/> Nutritionist/Dietician | <input type="radio"/> Neurologist | <input type="radio"/> Other: _____ |

Communication and Behavior Information

Does your child have any fears or anxieties?, If so, please explain. _____

How does your child handle change or transition? _____

Does your child like or dislike a particular academic subject? (Reading, writing, math, social studies, science, etc.) _____

Does your child like or dislike Art, Music, and PE? _____

Student Information Sheet (Page 3)

Name of Student:

Communication and Behavior Information

Does your child have any triggers or things that create frustration for them?

- change in schedule
- someone touching them
- someone saying or doing something in particular
- working in a group
- making a mistake
- social situations (structured/unstructured)
- peer interactions
- over stimulating situations
- not getting instant gratification
- unstructured time
- making decisions/ having too many choices
- when something unpredictable happens
- following directions
- staying on task
- not being first in line
- competitive situations (sports, games, etc.)
- teasing
- Other:
- Other:
- Other:
- Other:

Comments:

What coping skill does your child use or display?

- shuts down
- tantrums
- throwing or ripping up things
- physical aggression
- yells
- physical complaints (stomach or headache)
- challenges adult authority
- talks things out
- goes off quietly and calms down
- covers themselves with blanket
- ignoring
- runs away
- walks
- drawing/coloring
- listens to music
- play-doh
- jumps
- uses stress ball
- writes
- Other:
- Other:

Comments:

What anger cues does your child give when angry or frustrated?

- head pounding
- face gets red
- body shakes
- mad face
- stomach or headache
- eyes teary
- balled up fists
- nose flares
- verbal noises
- other:

Does your child have any special interests?

- Sports
- Play Station
- Game Boy/Nintendo
- animals
- characters (Sponge Bob, Star Wars)
- other:
- fishing
- music
- Karate
- skating/riding bikes

What kind of rewards work well with your child?

- food
- toys
- homework pass
- books
- time with teacher/adult
- taking walks
- computer time
- prize box
- earned breaks
- points/tokens

What kind of consequences work well with your child?

- time-out
- loss of computer time
- delay of reward
- isolation from peers
- loss of points/tokens
- loss of privileges
- ignoring
- other:
- other:

Comments:

Student Information Sheet (Page 4)

Name of Student: _____

In order for us to try and be consistent across the settings of school and home, help us to understand what rewards and consequences are used at home?

What kind of language is used to present rewards and consequences? (Example: "time-out", "cool your engine", "take-five")

Parent Comments and Concerns

What strategies and accommodations did you find to work well last year? _____

What concerns do you have about the upcoming school year? _____

What kinds of things would you like to see in the upcoming school year? _____

Name of Parent/s or Guardian filling out form: _____