

School _____

STUDENT QUESTIONNAIRE

Student Name _____

PREVIOUS SCHOOLING

Please list all previous attended (list name, address, and dates attended)

Previous services received (check all that apply):

- | | |
|---|---|
| <input type="checkbox"/> preschool or pre-K | <input type="checkbox"/> speech / language services |
| <input type="checkbox"/> reading Improvement | <input type="checkbox"/> ELL / Bilingual |
| <input type="checkbox"/> social work/counseling | <input type="checkbox"/> school nurse |
| <input type="checkbox"/> special education | |

List type and dates for any checked _____

Circle any grade(s) which the child has repeated: K 1 2 3 4 5 6 7 8 9 10 11 12

HEALTH INFORMATION

Does child currently take medication? Y () N () Name? _____

For what? _____ When? _____

Does child wear glasses? Y () N () Contact lenses? Y () N ()

Does child wear hearing aides? Y () N () Have Tubes? Y () N ()

Does child need preferential seating? _____

Does child have any allergies? _____

Does child have any other medical condition(s) which don't require medication? i.e. asthma, sinus problems). If yes, please list: _____

Please list all of the people who currently live in the same house with the student. (Include names, ages, and relationship). _____

