

School _____

STUDENT QUESTIONNAIRE

Student Name _____

Number of people in the house: _____

Is this a foster family? Y () N () Single-parent family? Y () N ()

Address of other parent (if applicable) _____ Phone # _____

Place of birth _____

Language spoken in the home? _____

What is the child's first language? _____

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 |
| <input type="checkbox"/> Reading Improvement | <input type="checkbox"/> ELL |
| <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)

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |