## PARENTAL/GUARDIAN IN-PUT FOR EVALUATION

Dear		<b>,</b>	
	_	about your child as we begin the evaluation this form to	ation process. Feel free to add any additional
Student's Last Name:		Student's First Name: _	
Birth Date:		M/F School District A	Attending:
Parent/Guardian Name		Home Phone:	
Address:		City/Zip:	
Child is presently living with:			
☐ Biological Mother	☐ Stepmother	☐ Adoptive Parent	☐ Foster Parent
☐ Biological Father	☐ Stepfather	☐ Adoptive Parent	☐ Foster Parent
Other (Specify):		Language Spoken in the Home	e:
Best time(s) to contact parent/gua	ardian by phone:		
FAMILY			
Parent 1 Name:		Occupation:	) 
School: Highest grade completed		_ Special Assistance in School? (ex	.: tutoring, etc.)
Medical/Emotional Concerns:			
Parent 2 Name:		Occupation:	
School: Highest grade completed		_ Special Assistance in School? (ex	.: tutoring, etc.)
Medical/Emotional Concerns:			
Name  1 2 3	ND/OR SISTERS Ag	e Medical/So	cial/School Concerns
4			
5.	<u> </u>		
6.			
PREGNANCY - Were there any	complications during p	regnancy with this child?	
PARENT ACADEMIC CONCER	NS and/or BEHAVIOR	CONCERNS:	

CHILD'S MEDICAL HISTORY Page 2 of 2

Childhood Diseases:  Hospitalizations for Illness:  Eye Problems:  Wears glasses or contact lenses:   yes   no    Operations:  Tics: (i.e. blinking, sniffing, etc.)  Ear Problems: (i.e. car infections)  Allergies or Asthma:  Convulsions: Childhood Diseases:  with fever   without fever    Please indicate any diagnosed conditions:  ADHD   Depression   ODD   Autism   Anxiety   Other:
Wears glasses or contact lenses:   yes   no
Wears glasses or contact lenses:   yes   no
Wears glasses or contact lenses:   yes   no
Head Injuries:   Ear Problems: (i.e, ear infections)
Head Injuries:   Ear Problems: (i.e, ear infections)
Head Injuries:
Head Injuries:
Convulsions: Childhood Diseases:  with fever without fever  Please indicate any diagnosed conditions:  ADHD Depression DDD  AUtism Anxiety Dther:
Convulsions: Childhood Diseases:  with fever without fever  Please indicate any diagnosed conditions:  ADHD Depression ODD Autism Anxiety Other:
Please indicate any diagnosed conditions:  ADHD Depression ODD Autism Anxiety Other:
Please indicate any diagnosed conditions:  ADHD Depression ODD Autism Anxiety Other:
□ ADHD □ Depression □ ODD □ Autism □ Anxiety □ Other: □ □
□ ADHD □ Depression □ ODD □ Autism □ Anxiety □ Other: □ □
□ ADHD □ Depression □ ODD □ Autism □ Anxiety □ Other: □ □
□ ADHD □ Depression □ ODD □ Autism □ Anxiety □ Other: □
SCHOOL HISTORY
Previous School Districts Attended: Special Services Received:
If you have any questions or need assistance in completing this form, please call
at
Them by your few yours assistance
Thank you for your assistance,

District/Cooperative Staff

Date