



INFORMATION SHEET FOR THE TEACHER

Child's name and nickname: _____

Date of birth: _____

Home phone: _____ Cell phone: _____

E-mail contact(s): _____

Child lives with (please include names, ages, and relationships):

Pets (names and types): _____

Parents' Occupation: _____

Persons authorized to pick up your child:

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

(OVER)

MEDICAL INFORMATION

Describe your child's general health:

Does your child have any medical condition (seizures, non-food allergies, etc.)?

Is your child allergic to any food or other substance? If yes, please list:

Is your child on a special diet? If yes, please describe:

Does your child regularly take any over-the-counter medications? If yes, please list:

Does your child take any prescription medications? If yes, please list:

What behavior or medical issue is the medication prescribed for?

Is your child receiving any special therapies at this time (occupational, psychological, physical, etc.)?

Has your child received any therapy in the past?

If 'yes' to either of the previous questions, describe the therapy and how it has affected your child.