

Student's Name _____ Date of Birth _____ GR. _____

Step 3: Specialized Services Section

- Does your child presently have an Individualized Education Plan (IEP)? Yes No
- Are you providing a copy of your child's IEP? Yes No
- Has your child had a screening test with Child Outreach? Yes No
- Does your child have a 504 Plan? Yes No
- Does your child presently receive any English as a Second Language instruction? Yes No
- Does your child receive any other services not already mentioned? If yes, please explain: Yes No

Step 4: Emergency Contacts & Release Procedures

In the event of a major illness or injury, 911 will be called first. **If you are unavailable**, we will contact the individuals below in the order listed in the event of an illness or emergency involving your child. The people listed should be available during school hours. Your child may also be released to these individuals under other circumstances at your request or the school's request. Suitable identification (driver's license) will be necessary before the child is released. These are the only people authorized to pick up your child from school. Please complete this section as accurately as possible.

I, _____ (parent/guardian name) authorize the school to release my child to the individuals named below:

<u>Name</u>	<u>Relationship to Child</u>	<u>Daytime Phone</u> <i>Indicate if Home, Work or Cell Number</i>
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

Step 5: Permission to Photograph/Video Tape Your Child

We are proud of our students and the special events that take place at our schools. Occasionally throughout the year we invite the press to report on our events. **CHECK THE BOX BELOW IF YOU DO NOT GIVE PERMISSION FOR YOUR CHILD TO BE PHOTOGRAPHED OR VIDEOTAPED.** **If we have your permission to photograph your child, you need to do nothing.**

I **do not** give my consent allowing my child to be photographed or video taped at school events and published in media and on the school web site.

Parent/Guardian Signature _____ Date: _____

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Step 6: Home Language Survey

PLEASE COMPLETE THIS FORM **WHETHER OR NOT** YOU SPEAK A LANGUAGE OTHER THAN ENGLISH.

HOME LANGUAGE SURVEY
Perguntas sobre a lingua que e mais usada em casa
Perguntas sobre el idioma usado en la casa

1a. WHAT LANGUAGE DID YOUR CHILD LEARN FIRST TO SPEAK? _____

1b. Qual foi a primeira lingua que o seu filho/a aprendeu a falar? _____

1c. Cual fue el primer idioma que su hijo/a aprendio a hablar? _____

2a. WHAT LANGUAGE DO YOU USE MOST WHEN SPEAKING TO YOUR CHILD? _____

2b. Qual e a lingua que usa com mais frecuencia quando fala com os seus filhos? _____

2c. Cual es el idioma que usa con mas frecuencia cuando habla con sus hijos? _____

3a. WHAT LANGUAGE DOES YOUR CHILD SPEAK MOSTLY WHEN SPEAKING TO YOU? _____

3b. Qual e a lingua que o seu filho usa com mais frecuencia quando fala consigo? _____

3c. Cual es el idioma que su hijo habla mas frecuentemente cuando habla con Ud.? _____

4a. WHAT LANGUAGE DOES YOUR CHILD USE MOSTLY WHEN SPEAKING TO OTHER ADULTS? _____

4b. Que lingua usa o seu filho com mais frecuencia quando fala com outros adultos? _____

4c. Cual es el idioma que su hijo usa con mas frecuencia cuando habla con otros adultos? _____

5a. WHAT LANGUAGE DOES HE/SHE USE WHEN SPEAKING TO SIBLINGS AND FRIENDS? _____

5b. Que lingua usa o seu filho para falar com os irmaos e amigos? _____

5c. Cual es el idioma que su hijo habla con los hermanos y amigos? _____

6a. IF YOUR CHILD WAS NOT BORN IN THE UNITED STATES, IN WHAT COUNTRY WAS HE/SHE BORN? _____

_____ **What year did he/she enter this country?** _____

6b. SI SU NIÑO NO NACIÓ EN LOS ESTADOS UNIDOS, EN QUÉ PAÍS NACIÓ ÉLELLA ? _____

_____ En qué año entró él/ella en este país? _____

6c. SE SUA CRIANÇA NÃO NASCEU NOS ESTADOS UNIDOS, EM QUE PAÍS NASCEAU? _____

_____ Em que ano entrou neste país? _____

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Step 7: Student Health Section

Physician's Name _____ Phone: _____

IF YOU ANSWER YES TO ANY QUESTION, PLEASE EXPLAIN

1. Has your child ever had any operations or serious illnesses? If yes, please explain. Yes No

2. Has your child had any serious accidents? If yes, please explain. Yes No

3. Does your child wear eyeglasses, contacts, braces, hearing aids, or any other corrective device? _____ Yes No

4. Has your child had the following (Give month, year and/or age if known):

Chicken Pox _____ Yes No Heart condition _____ Yes No

Pneumonia _____ Yes No Diabetes _____ Yes No

Nosebleeds _____ Yes No Seizures _____ Yes No

Frequent sore throats _____ Yes No High fevers _____ Yes No

Ear Infections _____ Yes No Migraines _____ Yes No

Eye condition _____ Yes No Other (please specify) _____

5. Has your child had a neurological evaluation? If yes, when? _____ Yes No

6. Has your child had a psychological evaluation? If yes, when? _____ Yes No

7. Is your child restricted from physical activities? If yes, please explain. Yes No

8. Is your child allergic to: medicines/drugs? If yes, please specify. Yes No

Is your child allergic to: plants/foods? If yes, please specify. Yes No

Is your child allergic to: insect stings? If yes, please specify. Yes No

9. If you answered yes to question #8, does your child take medicine for this allergy? Yes No

If yes, please specify. (i.e. Benadryl, Epi-Pen, etc.) _____

10. Does your child have asthma? If yes, date diagnosed: _____ Yes No

If yes, what medication(s) does he/she take: _____

11. Does your child take any daily medications? If yes, please specify. _____ Yes No

12. Will medications be given at school? _____ Yes No

13. What medications are given frequently, but not daily _____

14. Would you like a conference with the school nurse? _____ Yes No

Parent Name: (Please Print) _____

PARENT SIGNATURE: _____ DATE: _____