

CHILD'S MEDICAL & SOCIAL INFORMATION

(To be completed by parent/guardian/care-giver)

INSTRUCTIONS	➤ Please fill out completely. <u>Please Print.</u> ➤ Failure to do so may delay the decision
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IDENTIFYING INFORMATION

1. Child's Name _____ Today's Date _____
 Male Female Age ____ Height/Weight ____ / ____ Parish of Residence _____

Date of Birth	---	---	---	---	Social Security #	---	---	---	---
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2. Name of person providing information _____
 Relationship to child _____
3. Describe the child's condition and how it affects his or her daily activities.

4. At what age did the condition begin? _____
5. At what age was the condition first treated? _____

SCHOOL INFORMATION

6. What grade is the child currently attending? _____ Teacher's Name: _____
7. Please list school/ preschool information below for the last two years. If more space is required, add additional pages. Attach Individual Education Plan (IEP) or other Pupil Appraisal reports, if any.

Current School Name			Previous School Name	
Address			Address	
City, State			City, State	
Zip Code			Zip Code	
Phone #	()		Phone #	()
Dates Attended			Dates Attended	
Any Special Education Services Received? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Reason for Special Education:		Any Special Education Services Received? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Reason for Special Education:

8. Does child have any behavioral problems in school? Yes No If **Yes**, please describe.

Have behavioral problems resulted in any in-school or out-of -school suspensions? Yes No
If yes, Please explain _____

9. If child is school-age but is **not** in school, please explain why he or she is not in school.

10. Has child been tested for learning or behavioral problems at school? Yes No. If Yes, please list type of tests, and where and when testing was done.

ACTIVITIES

11. How does the child spend free time? List hobbies (reading, collecting, computer, etc.) and/or activities: (sports, dance, school activities, scouting, clubs, etc.) and how often he/she participates. _____

12. Have there been any changes in the child's activities or behavior since his or her condition began?
 Yes No

If **Yes**, please explain. _____

13. Does the child help with household chores? Yes No If **Yes**, what are the chores (make bed, feed pets, clean room, yard work, etc.) and how often are they done? _____

How much assistance does the child need to complete chores? _____

14. How does the child behave with adults (parents, teachers, neighbors)? Please give examples.

15. How does the child relate with peers (friends, other family members)? Please give examples.

16. Is the child able to care for himself/ herself in an age appropriate way? Please give examples.

MEDICAL AND HEALTHCARE INFORMATION

17. List all medications that the child currently takes for his/ her condition, and who prescribes it:

Name of Medication	Dosage & How often taken	Who Prescribed	Date of Last Visit with this Provider

18. How does the medication affect the child? _____

19. During the last 24 months, has the child received any testing or special examinations (for example: hearing or vision, IQ testing, blood tests, breathing tests, X-rays)? Please list these below, and include HeadStart, Early Intervention Services, Mental Health/ Mental Retardation Centers, etc.:

Name of Doctor/ Hospital/ Clinic/ Agency Include Specialists	Address, Zip Code & Phone #	Date of Test or Evaluation	Type of Test or Evaluation

20. Does the child's condition cause pain or discomfort? Yes No If **Yes**, how does this affect his/her daily activities? _____

21. During the last 12 months, where has the child received medical/ psychological treatment?
 Mental Health Clinic Private Physician/ Therapist Clinic Hospital Other Source
 Please List below:

Doctor/ Hospital/ Clinic Include Specialists Seen	Address, Zip Code & Phone #	Dates Treated	Reason for Treatment

OTHER INFORMATION

22. Has this child applied for Supplemental Security Income (SSI) benefits? Yes No
 If **Yes**, when? _____
 What is the status of the application? Approved Pending Appealed Denied Terminated
 If denied OR terminated, when? _____ Why? _____

23. Tell us any other information that you think we need to know about this child. _____

Name of Person Completing Form _____

Date _____

Phone _____