

Confidential Student Profile

- 1. Does your child have an Individual Educational Plan (IEP), 504 Plan, OHD –Other Health Disability Plan, or other educational plan from the public school district? ___ Yes ___ No

- 2. Does your child have a private school-generated education plan providing modifications? ___ Yes ___ No

If yes to questions 1 or 2, attach a copy of your child’s current educational plan (IEP, 504, or OHD) to this form.

- 3. Does your child receive support services in or out of their school day (special education/resource support, paraprofessional, one-on-one aide, private therapist, private tutor)? ___ Yes ___ No

- 4. Please check the appropriate box (es) that apply to your child:

- | | | |
|--|--|-------------------------------------|
| <input type="checkbox"/> Obsessive-Compulsive Disorder | <input type="checkbox"/> ADHD/ADD | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Developmental/Cognitive Delay | <input type="checkbox"/> Asperger’s Syndrome | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Conduct/Oppositional Defiant Disorder | <input type="checkbox"/> Hearing Impairment | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Emotional/Behavioral Disorder | <input type="checkbox"/> Visual Impairment | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Speech/Language Disability | <input type="checkbox"/> Learning Disability | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Physical Disability/Cerebral Palsy | <input type="checkbox"/> Epilepsy/Seizures | |
| <input type="checkbox"/> Tourette’s Syndrome | <input type="checkbox"/> Autism/PDD | |

- 5. Does this condition impact your child’s school performance? If yes, provide details. ___ Yes ___ No

- 6. Would you like us to contact you to discuss this information further? ___ Yes ___ No

- 7. Was a referral for assessment of concerns at school recently made or is one in progress? ___ Yes ___ No

If yes, please explain _____

- 8. Does your child take medication? If yes, provide names of medications(s) and if, needed during school hours, the times administered. ___ Yes ___ No

- 9. Other information regarding your child’s health or education that you would like to share.

Name and relationship to child of person completing this form

(Print Name)

(Signature)