MEDICAL AND SCHOOL WORKSHEET - CHILD

<u>Completing this worksheet will help you get ready for the interview.</u> It will also speed up the interview. We may ask for additional information. *If you need more space, use blank sheets of paper.*

A. Child's height and weight. _____

B. Name, address, phone number, and relationship of another adult who helps care for the child and can help us get information about the child if necessary.

_____

_____

C. The child's illnesses, injuries, or conditions. _____

_____

D. When the child's condition(s) began. _____

E. How they affect the child's activities. _____

F. The child's current grade, if in school. _____

G. Schools or preschools the child is currently attending, and any other schools he or she attended in the last 12 months.

NAME	ADDRESS, ZIP CODE, and PHONE NUMBER	DATES ATTENDED	KIND(S) OF SPECIAL ED. SERVICES *(if any)*

H. Current teacher's name(s) and school. _____

I. School testing the child has had, such as tests for behavior or learning problems.

NAME OR KIND OF TEST	DATE(S)	NAME OF SCHOOL

J. Name of any school therapist the child is seeing or has seen (*for example, speech, physical, or occupational*) and the school name.

_____

_____

K. Hospitals, clinics, doctors, or therapists that have seen the child within at least the last 12 months.

NAME	ADDRESS, ZIP CODE, and PHONE NUMBER	PATIENT I.D. NUMBER	DATE FIRST SEEN	DATE LAST SEEN

L. Other agencies or programs that tested or examined the child, or that provided services (*such as Headstart, Early Intervention Services or Special Education, Public or Community Health, Welfare or Social Service Agency, Mental Health/Mental Retardation Center*).

NAME	ADDRESS, ZIP CODE, and PHONE NUMBER	KIND OF TEST OR SERVICE	DATE(S)

M. Medicine(s) the child takes, and the doctor's name if it is a prescribed medication.

NAME OF MEDICINE	PRESCRIBED BY

N. All medical tests the child had or will have for his or her illnesses, injuries or conditions. (*For example, hearing test, vision test, IQ testing, blood tests, breathing tests, x-rays.*)

NAME OF TEST	DATE(S)	WHERE DONE	WHO SENT CHILD FOR TEST