

Student's Name: _____ **Grade Level:** _____

Supplemental Health Form

Please select the best answer and feel free to provide more information in the space provided below.

1. Was your child an easy baby? (i.e. did he/she cry a lot? Did he/she follow a schedule fairly well?)

Easy Average Difficult Very difficult

Comments: _____

2. If your child has siblings, how well does he/she get along with them? Please explain.

Comments: _____

3. How easily does your child interact with other adults, such as extended family and non-family members?

Very sociable Average sociability Unsociable Very unsociable

Comments: _____

4. How easily does your child make friends in his/her peer group?

Easy Average Difficult Very difficult

Comments: _____

5. When your child wants something, how insistent is he/she?

Very Insistent Average insistence Not very insistent Never Insists

Comments: _____

6. How would you rate the normal activity level of your child during the day?

Morning (AM) : Very active Active Average Less Active Not active

Afternoon (PM) : Very active Active Average Less Active Not active

7. Has your child had any accidents resulting in the following? *Check all that apply and give approximate date below.*

Injury	Date/Explain	Injury	Date/Explain
<input type="checkbox"/> Broken Bones _____		<input type="checkbox"/> Stomach pumped _____	
<input type="checkbox"/> Severe Lacerations _____		<input type="checkbox"/> Eye Injury _____	
<input type="checkbox"/> Head Injury _____		<input type="checkbox"/> Lost teeth _____	
<input type="checkbox"/> Severe Bruises _____		<input type="checkbox"/> Sutures _____	

8. Which phrase best describes your child's normal sleep habits?

- | | |
|--|--|
| <input type="checkbox"/> No problems sleeping at a normal bedtime | <input type="checkbox"/> Difficulty falling asleep |
| <input type="checkbox"/> Sleep continuity disturbance or sleep apnea | <input type="checkbox"/> Early morning awakening |
| <input type="checkbox"/> Restless sleeping (wakes up often during the night) | |
-

9. Does your child have any ongoing or chronic appetite problems (e.g., tends to under eat, tends to overeat, seems to eat normally most of the time)?

Explain: _____

10. Has your child ever been in any type of special education program in the past, such as working with a shadow teacher at school, attending regular pull-out sessions with a Learning Support Specialist at school, attending school as part of a special education class for the learning disabled, or participating in regular speech and/or language therapy sessions? **___ YES ___ NO**

If yes, please specify the nature of the special education assistance, including the dates and duration of the special education services. Please also provide copies of ALL recent and relevant reports and assessments from all Physicians, Psychologists and Special Educators involved with your child's case.

Comments: _____

11. Have any of the following stressful events occurred in the life of your child within the past 12 months?

Check all that apply:

- | | |
|---|---|
| <input type="checkbox"/> Parents divorced or separated | <input type="checkbox"/> Best friend or close relative moved away |
| <input type="checkbox"/> Death in the family | <input type="checkbox"/> Moved to a new house or neighborhood |
| <input type="checkbox"/> Serious financial problems | <input type="checkbox"/> One or both parents travel(s) frequently |
| <input type="checkbox"/> Family accident or illness | <input type="checkbox"/> Other (please specify) |
| <input type="checkbox"/> Death or loss of a beloved pet | |

Other information: _____

Parent or Legal Guardian's Signature: _____ **Date:** _____
