

Date: _____

Student Name: _____ Birth Date: _____

Address: _____

Student Grade: _____

School/Teacher: _____

Parent or Guardian Name	Primary Phone Number	Primary Email

If needed, list the parent(s) who have Educational Authority.

Emergency Contact Name/s : _____ Number/s: _____

Medical Conditions, optional: (ADD, ADHD, Autism, Epilepsy) _____

Please answer by checking the box "Yes" or "No" and provide the approximate date of evaluation.
 Please provide a copy of the report, if available.

	Yes	No	Date
Neuropsychologist or school psychologist? _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Speech-Language Evaluation? _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Medical Neurologist? _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Slingerland/MSI Screening? _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Did Public School tested your child for an IEP or Resource Room? _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
If yes, does your child have an active IEP or 504? _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Date of your child's last vision test. _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Does your child wear glasses? _____	<input type="checkbox"/>	<input type="checkbox"/>	_____

Please list your child's 1st and 2nd degree relatives* who struggled to learn reading, writing, spelling or math skills.
 Student's parents, full siblings, grandparents, grandchildren, aunts, uncles, nephews, nieces or half-siblings

Please share anything of importance about your student, for example previous tutoring, strengths & weaknesses, scheduling/logistics: