The Arbor School of Central Florida
Medical/Emergency Information
Please Print

Student's Name: _____
Student's Date of Birth: _____
Student's Address: _____
Student's Home Phone: _____
Primary Medical Diagnosis:_____

Mothers Name:	**Fathers Name**:
Work #	Work#
Cell phone #	Cell Phone #
Email Address:	Email Address:
Address same as student? Yes ☐ No ☐ (If no, please provide)	Address same as student? Yes ☐ No ☐ (If no, please provide)

Emergency Contact Name: _____
Emergency Contact #: _____

Allergies (List all: environmental, medicinal, food, latex):

ALLERGY	REACTION

Additional allergy information:
_____
_____
Special Diet/Restrictions:
_____
_____
Precautions: _____

Does student have history of seizures? Yes ☐ or No ☐

If yes, complete the following:
Frequency of seizures:_____
Precipitating Factors: _____
Pre-seizure Signs/symptoms: _____
Appropriate Measures:
_____
_____

ADDITIONAL MANDATORY EMERGENCY INFORMATION ON REVERSE

Permission to take student to nearest hospital or emergency medical services to be provided?

Yes☐ or No☐

If yes, please provide the following necessary medical information

Parent's signature: _____

Student's Primary Physician: _____

Physician's Address: _____

Physician's Phone #: _____

Student's Insurance Information: Carrier: _____

ID # _____ Group # _____

Insured Name: _____

Any other important medical information:

_____

_____

_____

_____

Parent Signature_____ Today's date_____

Demographics

Child is currently living with:

_____

Does your child have any siblings?

Name	Age	Any diagnosis?

Primary form of transportation to/from school and by whom:

_____

Medical History

Please list any of the following, starting with the most recent:

	Date	Details
Surgery		
Injury		
Illness		
Accident		
Hospitalization		

Additional information:

_____
_____
_____
_____
_____

Is there a history of ear infections? Yes☐ or No☐

If yes, how often and how were they treated? Were tubes placed?

_____

Is there a history of upper respiratory infections? Yes☐ or No☐
If yes, how often?
_____

Please check if your child has been diagnosed with any of the following:

	DIAGNOSIS	YEAR
	ADHD	
	Asperger's Syndrome	
	Asthma	
	Attention Deficit Disorder	
	Auditory Processing Disorder	
	Autism	
	Behavioral or Emotional Disorder	
	Cerebral Palsy	
	Down Syndrome	
	Epilepsy	
	Hydrocephalus	
	Mental Handicap	
	Pervasive Development Delay	
	Sensory Integration Disorder	
	Specific Learning Disability	
	Stroke	
	Traumatic Brain Injury	

Please list any other diagnosis your child has been given and when the diagnosis was made.
_____
_____

Please list the types of **medications** your child is taking (prescribed and/or over the counter) and for what reason.
_____
_____

**** PLEASE BE ADVISED THAT ANY CHANGE/ ALTERATIONS MADE TO ANY OF YOUR CHILDS MEDICATIONS MUST BE DOCUMENTED IN WRITING AS SOON AS IT HAPPENS****
This includes decisions made by parents or medical professionals. It is vital in keeping up to date records on your child and allows us to provide the appropriate accommodations within the classroom in case of adverse reactions.

Has your child had his/her hearing tested? Yes☐ or No☐
If yes, please provide the date and results.
_____

Please check if your child has had his/her vision tested by :

	Developmental Optometrist	Date:	Results:
	Ophthalmologist (typical vision testing)	Date:	Results:

Does your child participate in any sports or activity that encourages strength and endurance? Please describe:_____
_____
_____

Are there any physical limitations that we should be aware of that may affect their participation in recess/ PE activities:
_____
_____
_____

Are there any specific precautions that should be taken to assure your child's safety?
_____
_____

Developmental History

Please describe the mother's general health during the pregnancy (Illness, accidents, medications, or any complications)
_____
_____

Was your child born on time, early, or late?
_____

Were there any complications at birth? If yes, please explain.
_____

Was your child irritable as an infant? If yes, please describe.
_____
_____

At what age did your child accomplish the following developmental skills?

SKILL	AGE	SKILL	AGE
Sit unsupported		Use single words	
Crawl on hands and knees *For how long?		Combine two words	
Stand			
Walk			
Run		Pedaling tricycle or bicycle	
Feed self		Ride bicycle w/ training wheels	
Toilet train		Ride bicycle w/out training wheels	

Has your child received Occupational therapy services in the past? Yes☐ or No☐

If yes, please specify the date and focus of those therapeutic services. If they are still receiving outside therapy services, please state CURRENT.

_____

_____

_____

Please check the following skills that your child has **mastered**:

Undressing		Unfastening zippers		Daytime bowel/bladder continence		Using a cup	
Dressing self		Fastening zippers		Night time continence		Using a straw	
Putting on socks/shoes		Unfastening buttons		Undressing independently for toileting		Using a fork	
Taking off socks/shoes		Fastening buttons		Dressing independently after toileting		Using a spoon	
Tying a knot		Unfastening snaps		Complete independence with toileting routine		Using a knife (safely)	
Tying a bow		Fastening snaps					

Does your child have spillage while using a spoon, fork, cup, or straw? Yes☐ or No☐

If yes, please specify.

_____

_____

Feeding/Food

Are there or have there been feeding problems with your child (e.g. problems with sucking, swallowing,drooling, chewing, etc.).

Yes☐ or No☐

If yes, please describe.

_____

_____

Does your child prefer certain textures of food? Yes☐ or No☐
If yes, please describe.

_____
_____

Does your child avoid certain textures of food? Yes☐ or No☐
If yes, please describe.

_____
_____

What does your child typically eat?

_____
_____

Speech and Language

What is the primary method your child uses for letting you know what he/she wants?

____Looking at objects	_____ Pointing at objects	_____ Gestures
____ Crying	_____ Making sounds	_____ Gestures and sounds
____ Pushing/pulling	_____ Single words	_____ Sentences
____ 2-3 word combinations		_____ Uses assistive device

What languages are spoken at home?_____

What is the child's primary language?_____

Does your child speak any other language(s)?_____

Does your child interact better with children or adults?_____

How does your child respond to given instructions?

_____
_____

Has your child received Speech Therapy services in the past? Yes☐ or No☐
If yes, please list the date and primary focus of those therapy services. If currently receiving them from an outside source, please write CURRENT.

_____
_____

Does your child receive any additional therapy services privately? (e.g. counseling, behavioral, physical therapy, hippotherapy, acupuncture or massage)
If yes, please describe.

_____
_____
_____
_____

Educational History

What grade and school is your child currently enrolled in?

_____

Check the programs in which your child participates in at school:

_____ Regular Classroom
_____ Specific Learning Disabled (SLD)
_____ Self –Contained Language Classroom
_____ Educable Mentally Handicapped (EMH)
_____ Profoundly Mentally Handicapped (PMH)
_____Gifted
_____ Inclusion Classroom
_____ Varying Exceptionalities (VE)
_____ Emotionally Handicap (EH)
_____ Trainable Mentally Handicapped (TMH)
_____ English for speaker of other languages (ESOL)
_____ Other

Has your child repeated a grade? If yes, which? Why?

_____

Has your child been assigned to a higher-grade level without passing the previous grade? If yes, which?

_____

Does your child have any difficulties at school? If yes, please describe.

_____
_____
_____

In the past, has your child had any situations within a school setting that resulted in a consequence/ disciplinary action?

Yes☐ or No☐

If yes, please describe the situation and any possible "triggers" that may have lead up to the event.

_____
_____
_____

Has your child displayed any negative or aggressive behaviors we should be aware of in other settings (biting, hitting, pinching, unfavorable language, inappropriate actions)

Yes☐ or No☐

If yes, please explain. This information is vital in ensuring the safety of staff and classmates

_____
_____
_____

Please include any additional information, which you would like to share about your child.

_____
_____

School Year Concerns and Goals

Please describe your current concerns regarding your child's difficulties, if any, in the following areas:

Feeding:
_____
Speech:
_____
Language:
_____
Hearing:
_____
Visual:
_____
Motor/Movement:
_____
Emotional:
_____
Behavioral:
_____
Sensory/Fine Motor:
_____

Parents: Please provide 3 personal and realistic goals for your child.

Therapy Goals (For example: "I would like for my child to learn to tie his shoes" (OT goal)," I would like for my child to be able to answer yes or no questions" (SLP Goal)

1._____
2._____
3_____
What are your current expectations of therapy services for this school year?
_____
_____
_____

Classroom Goals- 3 realistic goals for your child to achieve by the end of this school year.

1._____

2._____

3._____