CENTER SOCIAL DEVELOPMENTAL HISTORY

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| Child’s Information | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Legal Name: | | | | | Child’s Legal Name | | | | | | | | | | Preferred Name: | | | | | | Child Preferred Name | | | | | | | |
| Birth Date: | | | | Birth Date | | | | Gender: | | Gender | | | | Age: | | Age | | | | | Grade: | | | | Grade | | | |
| School: | | Full Name of School | | | | | | | | | | | | | | | | | Teacher: | | | | | Teacher | | | | |
| Parent Name: | | | | | | Parent(s) Name(s) | | | | | | | | | | | | | | | | | | | | | | |
| Home Address: | | | | | | | Street Address | | | | City: | | | City | | | | | | | | Zip Code: | | | | | Zip Code | |
| Phone: | Phone Number | | | | | | | | Choose | | | | Parent email: | | | | Parent email | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| How does your child usually communicate with you (check all that apply)? | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Gestures/pointing Single words Short phrases Sentences Single signs Signed phrases | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ASL sentences Pantomime Signed English sentences Cued speech | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Other: | | | Other ways your child communicates with you | | | | | | | | | | | | | | | | | | | | | | | | | |
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| How do you communicate with your child? | | | | | | | | | | | | How you communicate with your child | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Language(s) used within the home (please check all that apply): | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Spoken English Spoken Spanish Sign Language Other: | | | | | | | | | | | | | | | | | | | | Other Language(s) | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | |  | | | | |  |
| Is this referral related to any type of legal or court proceeding? | | | | | | | | | | | | | | | | | | If yes, explain | | | | | | | | | | |
| Is this referral related to a potential change in educational placement? | | | | | | | | | | | | | | | | | | | | | If yes, explain | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | |  | |  |
| What do you enjoy most about your child? | | | | | | | | | | | | | | | | | | | | | | | | | |  | |  |
| Explain | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| What do you find most challenging about raising your child? | | | | | | | | | | | | | | | | | | | | | | | | | |  | |  |
| Explain | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| What would you like to see, or what do you see, your son/daughter doing after high school? | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Explain | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| What level of education do you hope your child will complete? Choose an item | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

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| --- | --- | --- | --- | --- | --- | --- |
| Family Information | | | | | | |
|  | |  | |  | | |
| Child is living with: | Both Parents Mother Father Mother and Stepfather | | | | | |
|  | Father and Stepmother Legal Guardian Other: | | | | | Other |
| Is the child adopted? Select If yes, child’s age at adoption: | | | Age | | | |
| Parental marital status: Select Marital Status | | | | | | |
| If parents are separated or divorced, who has custody of this child? | | | | | Custody | |
| How often does the other parent see this child? Select frequency of visitation | | | | | | |

Other Children (Including step-siblings and half siblings): No other children/siblings

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Name | Gender | Age | Relationship to Student | In home | School/behavioral/health Problems |
| Name of child | Gender | Age | Select | Select | Explain |
| Name of child | Gender | Age | Select | Select | Explain |
| Name of child | Gender | Age | Select | Select | Explain |
| Name of child | Gender | Age | Select | Select | Explain |
| Name of child | Gender | Age | Select | Select | Explain |

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| --- | --- | --- |
| If any other individuals are living in the home, please list their names and relationship to the student | | |
| here: | Name; Relationship to child | |
| Any special living circumstances or recent changes that may impact your child? Select | | |
| Explain: | | Explain |

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| --- | --- | --- | --- | --- |
|  | Birth Mother | Birth Father | Adoptive Mother, Stepmother, Legal Guardian, etc. | Adoptive Father, Stepfather, Legal Guardian, etc. |
| NAME: | Name | Name | Name | Name |
| Highest grade completed **or** Degree: | Education Level | Education Level | Education Level | Education Level |
| Occupation: | Occupation | Occupation | Occupation | Occupation |
| Learning difficulties | Select | Select | Select | Select |
| Psychological or psychiatric problems | Select | Select | Select | Select |
| ADHD | Select | Select | Select | Select |

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| Biological Extended Family | | | | | | | | | | | |
|  | | | | | | | | | | | |
| Do any extended family members (maternal/paternal grandparents, uncles, aunts, cousins) have: | | | | | | | | | | | |
| ADHD; specify who: | | Who | | | | | | | | | |
| Epilepsy; specify who: | | | | Who | | | | | | | |
| Seizures; specify who: | | | Who | | | | | | | | |
| Alcoholism or substance abuse; specify who: | | | | | | | Who | | | | |
| Psychological/emotional/personality difficulty; specify who: | | | | | | | | | | Who | |
| Learning problems/differences; specify who: | | | | | | Who | | | | | |
| Cognitive or Developmental challenges; specify who: | | | | | | | | | Who | | |
| Neurological disorder; specify who: | | | | | Who | | | | | | |
| Other; please list: | Other challenges | | | | | | | Specify who: | | | Who |

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| Developmental Information | | | | | | | | | | | | | | | | | | |
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| At what age did this child first do the following? (Please indicate year or month of age for each) | | | | | | | | | | | | | | | | | | |
| Turn over | Age | | Sit alone | | Age | | Crawl | | Age | | Stand alone | | | Age | Walk alone | | | Age |
| Walk downstairs | | Age | | Walk upstairs | | Age | | Toilet trained days | | | | Age | | Toilet trained nights | | | | Age |
| Did your child: Belly crawl Crawl on hands and knees Did not crawl | | | | | | | | | | | | | | | | | | |
| Did accidents occur after toilet training: | | | | | | | | | | | | |  | | | |  | |
| Soiling (encopresis)? Select If yes, until what age | | | | | | | | | | | | | | | | Age | | |
| Wetting (enuresis)? Select If yes, until what age | | | | | | | | | | | | | | | | Age | | |
| Medical reasons for toileting accidents? Select reason: | | | | | | | | | | Reason | | | | | | | | |

Did/Does your child have:

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| --- | --- | --- | --- |
| Motor Difficulties (walking, skipping, catching, riding a bike) | Select | Describe: Explain | What age(s): Age(s) |
| Sleeping Problems | Select | Describe: Explain | What age(s): Age(s) |
| Difficulty Separating From Parents | Select | Describe: Explain | What age(s): Age(s) |
| Excessive Crying | Select | Describe: Explain | What age(s):  Age(s) |
| Over/Underweight (or Failure to Thrive) | Select | Describe: Explain | What age(s): Age(s) |
| Feeding Problems | Select | Describe: Explain | What age(s): Age(s) |

Please list any unusual, traumatic, or possible stressful events in the child’s life that you think may have had an impact on his/her development/current functioning: NONE UNKNOWN

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| --- | --- | --- |
| Event | Age of child at event | Comments |
| Event | Age | Explain |
| Event | Age | Explain |
| Event | Age | Explain |

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| --- | --- | --- | --- | --- | --- | --- |
| Sensory Processing Information | | | | | | |
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| Indicate if your child has any atypical response to the following (please give examples): | | | | | | |
| Touch (i.e., does not like light touch, needs deep pressure hugs, etc.): | | | | | | |
| Explain | | | | | | |
| Taste (i.e., does not like slimy, prefers sweet or spicy, avoids food with textures, etc.): | | | | | | |
| Explain | | | | | | |
| Texture (i.e., avoids or seeks rough, slimy, sticky, gel, satin, etc.): | | | | | | |
| Explain | | | | | | |
| Movement (i.e., becomes overly excited with movement, swinging calms them down, etc.): | | | | | | |
| Explain | | | | | | |
| Limited food intake (i.e., list specific likes or dislikes, picky eater, etc.): | | | | | | |
| Explain | | | | | | |
| Environmental (i.e., easily overstimulated in stores or restaurants): | | | | | | |
| Explain | | | | | | |
| Additional Sensory Comments: | | | Additional Sensory Information | | | |
|  | | | | | | |
| Please indicate whether this child exhibits any of the following behaviors: | | | | | | |
| Overreacts when faced with a problem | | | | | Seems impulsive | Easily overstimulated |
| Seems overly energetic in play | | | | | Lacks self-control | Short attention span |
| Seems uncomfortable meeting new people | | | | | Seems unhappy | Withholds affection |
| Needs significant parental attention | | | | | Hides feelings | Cannot calm down |
| Has unusual fears; what: | List the unusual fears | | | | | |
|  | |  | | | | |
| What upsets or frustrates your child? | | | | List what upsets your child | | |
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| Please describe any behaviors that are particularly concerning to you or others: | | | | | | |
| Concerning behaviors | | | | | | |

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| Pregnancy Information | | | | | | | |
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| Was the child’s mother under the care of a doctor or midwife? Select | | | | | | | |
| Check any of the following complications that occurred during pregnancy: | | | | | | | |
| Anemia | | Excessive vomiting | | | | | Rh incompatibility |
| Cytomegalovirus | | Flu/cold | | | | | Toxemia |
| Emotional problems | | High blood pressure | | | | | Vaginal bleeding |
| Excessive swelling | | Measles | | | | | Virus (e.g., Zika, H1N1) |
| Other: | Other medical issues not listed | | | | | | |
| Maternal injury: | | | Select If yes, describe: | | Describe injury | | |
| Hospitalization during pregnancy: | | | Select If yes, reason: | Reason for hospital stay | | | |
| Medications during pregnancy: | | | Select If yes, describe: | | Prescribed medications | | |
| Alcohol during pregnancy: | | | Select If yes, frequency: | | | Frequency | |
| Cigarettes used during pregnancy: | | | Select If yes, frequency: | | | Frequency | |

Other drugs used during pregnancy: Select If yes, describe below:

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| Type of drug | | | | | | | | Frequency | | | | | | | | Prescription | | | | | |
| Type of drug | | | | | | | | How often taken | | | | | | | | Select | | | | | |
| Type of drug | | | | | | | | How often taken | | | | | | | | Select | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | |
| Birth Information | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | |
| Check here if you have limited information pertaining to birth history and proceed to the *Additional Medical Information* section below | | | | | | | | | | | | | | | | | | | | | |
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| Where was the child born? (hospital, city) | | | | | | | | | | Birth Hospital, City where located | | | | | | | | | | | |
| Length of pregnancy: | | Length | | | | weeks | | | | | | Birth weight: | | | Weight | | lbs. | | | Weight | oz. |
| Child’s condition at birth: | | | | Select status | | | | | | | | Mother’s condition at birth: | | | | | | | Select status | | |
|  | | | | | | | | | | | | | | | | | | | | | |
| Check any of the following complications that occurred during/just after birth: | | | | | | | | | | | | | | | | | | | | | |
| Breech birth | | | Caesarean delivery | | | | | | | | | | Forceps used | | | | | Labor induced | | | |
| Other delivery complications, describe: | | | | | | | | | Explain | | | | | | | | | | | | |
| Incubator: how long? | | | Length of time in an incubator | | | | | | | | | | | | | | | | | | |
| Jaundiced | Bilirubin lights: | | | | How long under lights? | | | | | | | | | Length of time under bilirubin lights | | | | | | | |
| Breathing problems right after birth, describe: | | | | | | | | | | | | | Explain breathing problems | | | | | | | | |
| Supplemental oxygen: How long? | | | | | | Length of time on supplemental oxygen | | | | | | | | | | | | | | | |
| Sent to NICU: How long was stay? | | | | | | | Length of stay in NICU and/or PICU | | | | | | | | | | | | | | |
| NO COMPLICATIONS DURING/AFTER BIRTH | | | | | | | | | | | | | | | | | | | | | |
| Any medical diagnosis at birth? Select If yes: | | | | | | | | | | | | | List birthmedical diagnoses | | | | | | | | |
| List all medical diagnoses given in infancy: | | | | | | | | | | | Additional medical diagnoses in infancy | | | | | | | | | | |

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| Additional Medical Information | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | |
| The child’s current health is: Choose health status | | | | | | | | | | | | | | | | |
| Child had a head injury? Select | | | | | | | | | Lose consciousness? Select | | | | | | | |
| How long? | | Length of time | | | | Comatose? Select If yes, how long? | | | | | | | | | Length of time | |
| Has the child ever had a neurological exam? Select If yes, exam date: | | | | | | | | | | | | | | | | Exam Date |
| Neurologist’s Name: | | | | Doctor Name | | | | | | | | City: | | City | | |
| Reason for Exam: | | | Reason for neurological exam | | | | | | | | | | | | | |
| List all medical diagnoses the child has been given to date: | | | | | | | | | | | All diagnoses to date | | | | | |
| Has any genetic testing been conducted? Select By whom: | | | | | | | | | | | | | Doctor name | | | |
| Results: | Results of genetic testing | | | | | | | | | | | | | | | |
| Date of last vision test: | | | | | Date | | Prescription eyewear? Glasses Contacts None | | | | | | | | | |
| Reason for vision testing and/or prescription: | | | | | | | | Vision Information | | | | | | | | |
| Has your child’s information been shared with the DeafBlind Registry? Select | | | | | | | | | | | | | | | | |
| Is your child being tested for any other concerns? Select | | | | | | | | | | List concerns | | | | | | |

Please list any prescription medications currently being taken by the child

|  |  |  |  |
| --- | --- | --- | --- |
| Medication | Dosage | Times Per Day Taken | Reason |
| Medication Name | Dosage | Doses per day | Reason for prescription |
| Medication Name | Dosage | Doses per day | Reason for prescription |
| Medication Name | Dosage | Doses per day | Reason for prescription |

Surgeries and/or hospitalizations (please list **ALL**):

|  |  |  |  |
| --- | --- | --- | --- |
| Description or Name of surgery/hospitalization | Age of child | Length of hospital stay | Reason |
| Description | Age | Length of stay | Reason for surgery/hospitalization |
| Description | Age | Length of stay | Reason for surgery/hospitalization |
| Description | Age | Length of stay | Reason for surgery/hospitalization |
| Description | Age | Length of stay | Reason for surgery/hospitalization |

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| **Audiological Information** | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |
| Did child pass the Universal Newborn Hearing Screening? Select | | | | | | | | | | | | | | |
| Age at which hearing loss was identified by an audiologist: | | | | | | | | Age identified by audiologist | | | | | | |
| Has a cause been determined for your child’s hearing loss? | | | | | | | | | Select | | | | | |
| Cause: | Cause of hearing loss | | | | | | | | | | | | | |
| When was your child’s last hearing test? | | | | Date | | | Where? | | | Location | | | | |
| Would you describe the child’s hearing loss as: Choose description | | | | | | | | | | | | | | |
| Has the child had any genetic testing related to the hearing loss? | | | | | | | | | Select | | | | | |
| Results: | Results of testing | | | | | | | | | | | | | |
| Does the child have a history of ear infections? | | | | | | | | | Select | | | | | |
| If, YES: First occurrence: | | | Date | | Frequency: | How often | | | | | Most recent: | | Date | |
| Treatment(s): | | Describe treatment(s) | | | | | | | | | | | | |
| Has the child ever had ear tubes (PE tubes) surgically inserted? Select When: | | | | | | | | | | | | Date | | |
| Second set date: | | | | | | | | | | | | Date | | None |
| Third set date: | | | | | | | | | | | | Date | | None |

Please complete the following amplification table:

|  |  |  |  |
| --- | --- | --- | --- |
| Technology |  | Age Received | Currently Use |
| Hearing aid **Right** ear | Select | Age | Select |
| Hearing aid **Left** ear | Select | Age | Select |
| Cochlear Implant **Right** side | Select | Age | Select |
| Cochlear Implant **Left** side | Select | Age | Select |
| BAHA **Right** side | Select | Age | Select |
| BAHA **Left** side | Select | Age | Select |
| FM/DM system | Select | Age | Select |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| If your child has cochlear implant(s) or BAHA(s) when was the surgery? | | | | | 1st | Date | 2nd | Date |
| Activation? | | | | | 1st | Date | 2nd | Date |
| Any revisions to implant(s)? Select If yes, when: | | | | | | Date | | |
| Reason for revision: | | Reason for revision | | | | | | |
|  | | | | | | | | |
| How many hours each day does the child use amplification? Choose hours per day amplification use | | | | | | | | |
|  | | | | | | | | |
| With amplification, describe your child’s listening skills: | | | | Describe | | | | |
| Does your child regularly see an audiologist/clinic for hearing and device checks? Select | | | | | | | | |
| If yes, who/where: | | Name of audiologist/location of office | | | | | | |
| Please check all medical conditions that apply (indicate right ear, left ear, or both): | | | | | | | | |
|  | Dizziness or unsteadiness | | | | | | | |
|  | Ear deformity | | | Select to specify ear | | | | |
|  | Ear drainage | | | Select to specify ear | | | | |
|  | Ear pain/ earaches | | | Select to specify ear | | | | |
|  | History of ear wax build up | | | Select to specify ear | | | | |
|  | Tinnitus/ringing/noises in ears | | | Select to specify ear | | | | |
|  | Other: | | Other ear-related medical issues | | | | | |
|  | NO AUDIOLOGICALLY-RELATED MEDICAL CONDITIONS TO DATE | | | | | | | |

Are there Deaf or hard of hearing family members? Select

|  |  |  |
| --- | --- | --- |
| Family Member | Relationship to child | Age of onset for hearing loss |
| Name | Relationship to child | Age |
| Name | Relationship to child | Age |
| Name | Relationship to child | Age |

|  |  |  |
| --- | --- | --- |
| Language Information | | |
|  | | |
| Approximately how much of your child’s communication do you understand? Select estimate | | |
| Approximately how much of your child’s communication do others outside of family understand? | | |
| Select estimate | | |
| Is your child using any form of alternative/augmentative comm. (e.g., tech, pictures)? Select | | |
| What system? | Name of AAC system | |
|  | | |
| Did speech development ever seem to stop/ regress for a period of time? | | Select |
| Does the child seem to understand what you say/sign to him or her? | | Select |
| Does your child consistently answer to his/her name? | | Select |
| Does your child make appropriate eye contact with others? | | Select |
| Does your child follow simple commands? | | Select |
| Does your child ever have trouble remembering what you have told them? | | Select |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Behavioral and Mental Health Information | | | | | | | |
|  | | | | | | | |
| Has the child ever had a psychological or psychiatric exam? Select | | | | | | | |
| Doctor’s name: | Doctor Name | | | City: | City | Date of Exam: | Date |
| Reason for Exam: | | Reason for exam | | | | | |
|  | | | | | | | |
| Child ever been diagnosed by a psychologist/physician/other professional? (ADHD, Anxiety, etc.) | | | | | | | |
| Select If yes, what/when: | | | Diagnosis/when | | | | |

Has the child or family received any professional mental health treatment, such as individual or family counseling, group counseling, etc.? Select If yes (please complete below chart)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Mental Health Treatment | Type of counseling | Age of student during treatment | Name of Agency/ Counselor | Length of treatment |
| Treatment | Select type | Age | Name | Length |
| Treatment | Select type | Age | Name | Length |
| Treatment | Select type | Age | Name | Length |

|  |
| --- |
| Educational Information |

Describe any speech, language, hearing, OT, PT, psychological, special education services, tutoring that the child is receiving/ has received (school and private): Did not receive services Unknown

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Type of Therapy | Therapist | Frequency | Place  (Private/school) | Group or Individual | Duration  (e.g., age 3-5) |
| Type of therapy | Therapist name | Time | Place | Select | Duration |
| Type of therapy | Therapist name | Time | Place | Select | Duration |
| Type of therapy | Therapist name | Time | Place | Select | Duration |
| Type of therapy | Therapist name | Time | Place | Select | Duration |

List **all** previous school and grades attended:

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Name of School | City, State | Grades Attended | Academic Concerns | | Modified Curriculum | | Special Education Services | | RTI/MTSS, 504, IEP, Resource, etc. | |
| School | Location | Grade(s) | Select | | Select | | Select | | Services received | |
| School | Location | Grade(s) | Select | | Select | | Select | | Services received | |
| School | Location | Grade(s) | Select | | Select | | Select | | Services received | |
| School | Location | Grade(s) | Select | | Select | | Select | | Services received | |
| School | Location | Grade(s) | Select | | Select | | Select | | Services received | |
| Has the student been retained? Select If yes, grade(s): | | | | | | Grades repeated | | | | |
| Did your child receive early intervention services? Select | | | | | | | | | |
| Please list all therapy received while enrolled in early intervention: | | | | | | | | | |
| Type of Therapy | | | Therapist | Frequency | | | | Duration  (e.g., 12 mos. – 24 mos.) | |
| Type | | | Name | How often | | | | Age received service | |
| Type | | | Name | How often | | | | Age received service | |
| Type | | | Name | How often | | | | Age received service | |
| Type | | | Name | How often | | | | Age received service | |

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| --- | --- | --- | --- | --- | --- |
| Are there other Deaf or hard of hearing children at the current school? | | | | Select | |
| Any Deaf or hard of hearing children in your community? | | | | Select | |
|  | | | | | |
| Additional information you would you like us to know: (additional concerns, child’s interests, etc.) | | | | | |
| Additional information | | | | | |
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| Additional information | | | | | |
|  |  | |  | |  |
| Signature: | Name of person filling out form | | Date: | | Date |
| Relationship to child: | | Relationship to child | | | |
| *If you are the legal guardian, please provide a copy of the court/legal documents.* | | | | | |