

HOME HEALTH INFORMATION

Full Name: _____ Nickname (If Any): _____

Birthdate: _____

Street Address: _____ P.O. Box #: _____

City, State, Zip: _____

Home Telephone #: _____ Home Email: _____

Parent/Guardian 1 Name: _____ Cell #: _____

Occupation & Employer: _____

Work Email: _____ Work #: _____

Parent/Guardian 2 Name: _____ Cell #: _____

Occupation & Employer: _____

Work Email: _____ Work #: _____

DOES YOUR STUDENT HAVE ANY:

- Allergies? _____
- Difficulties with speech, vision, or hearing? _____
- History of hospitalization or surgery? _____
- Daily medication(s)? _____
- Special interests? _____
- Fears? _____
- Responsibilities at home? _____

What parent/guardian(s) does your student live with?

Please list the names and ages of your student's siblings: _____

Please list the name of your student's preschool and years attended, if any:

Additional information that would help us understand your student better:
