Student Special Services

To help us serve your child, please answer the following questions:

Date: _____
Student Name_____ Birth Date_____
Grade Level_____
Has your child been retained _____Yes _____ No If yes, what grade _____

Has your child had difficulty in (please circle):

Reading	Yes	No
Math	Yes	No
Spelling	Yes	No
Written Language	Yes	No
Behavior	Yes	No
Emotional Concerns	Yes	No
Physical Problems	Yes	No

If yes to any of the above, please explain:

_____

_____

Please circle any of the services that your child has received and indicate the date received:

Title I
Adaptive Physical Education
Speech/Language Therapy
Special Education Preschool
Specialized Transportation (per an IEP)
Counseling
Reading Assistance
Tutoring
Occupational Therapy
Physical Therapy
Resource
Vision Impairment
Hearing Impairment
Special Class (self-contained)
Other_____

Does your child have a current IEP _____Yes _____ No

Has your child qualified for gifted programs_____ Yes _____ No

Is there anything special we need to know about your child?

_____

_____