



UPDATE FORM

STUDENT: _____

DATE OF BIRTH: _____

GRADE: _____

ADDRESS: _____

HOME PHONE: _____

MOTHER'S WORK/CELL PHONE: _____

FATHER'S WORK/CELL PHONE: _____

PARENT'S EMAIL ADDRESSES: _____

EMERGENCY CONTACT: _____ PHONE: _____

PEDIATRICIAN NAME: _____ PHONE: _____

1. What did your child do over the summer _____

2. Have there been any changes over the summer, which may impact on your child during the school year? _____

3. Do you foresee any events/challenges that may occur during the school year which may impact upon your child? _____

4. Please detail any specific behavior management or discipline techniques you use at home: _____

5. Has your child has been given a medical/mental health diagnosis? ____ Yes ____ No

If yes, please explain: _____

6. Does your child receive services from any of the following:

	YES	NO	Frequency	NAME	PHONE
Speech/Language					
Occupational Therapy					
Physical Therapy					
Psychologist/Social Worker					
Psychiatrist					
Other:					

7. Please detail medical concerns - Please provide any relevant details regarding the above

services: _____

8. Please list all allergies or any special medical concerns _____

9. Does your child take regular medications: ____ Yes ____ No

If yes, please detail:

Drug Name	For Treatment of	Dose	Frequency/times
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

10. Do you use these medicines on weekends or during school holidays? ____ Yes ____ No

11. Please detail any special dietary concerns: _____

12. Social/Behavioral Profile – please check any of the following behaviors that describe your child:

- | | |
|--|---|
| <input type="checkbox"/> Difficulty dressing independently | <input type="checkbox"/> Difficulty with gross motor skills (running, etc.) |
| <input type="checkbox"/> Difficulty with cutting, coloring | <input type="checkbox"/> Thumb sucking |
| <input type="checkbox"/> Rocking | <input type="checkbox"/> Bedwetting |
| <input type="checkbox"/> Nightmares | <input type="checkbox"/> Unreasonable fears |
| <input type="checkbox"/> Temper tantrums | <input type="checkbox"/> Frequently talks to self |
| <input type="checkbox"/> Nail biting | <input type="checkbox"/> Unusual eating habits |
| <input type="checkbox"/> Personal hygiene is age appropriate | <input type="checkbox"/> Daydreams |

- | | |
|--|---|
| <input type="checkbox"/> Short attention span | <input type="checkbox"/> Lacks self control |
| <input type="checkbox"/> Inconsistency in moods or behavior | <input type="checkbox"/> Shy or withdrawn |
| <input type="checkbox"/> Aggressive towards others | <input type="checkbox"/> Needs constant approval or reassurance |
| <input type="checkbox"/> Difficulty with changes in routine | <input type="checkbox"/> Difficulty with organization |
| <input type="checkbox"/> Creative | <input type="checkbox"/> Athletic |
| <input type="checkbox"/> Musical | <input type="checkbox"/> Mechanical |
| <input type="checkbox"/> Artistic | <input type="checkbox"/> Self-confident |
| <input type="checkbox"/> Lacks motivation | <input type="checkbox"/> Doesn't seem to understand questions or directions |
| <input type="checkbox"/> Difficulty using numbers | <input type="checkbox"/> Avoids reading |
| <input type="checkbox"/> Difficulty telling time | <input type="checkbox"/> Frequently tells lies |
| <input type="checkbox"/> Difficulty making and keeping friends | <input type="checkbox"/> Gets ideas quickly |
| <input type="checkbox"/> Cooperative | |

Please comment on any behaviors that particularly concern you: _____

13. Indicate what you believe are your child's strengths and needs (including any special talents and interests): _____

14. Please describe any teams or clubs that your child enjoys: _____

15. Please share any other things we should know about your child: _____

16. Please indicate if you wish to speak with any of our staff (student's case manager, division chair, Director or any related service personnel) prior to the beginning of the school year.

*Attached you will find a release of information form. This enables the school psychologist and sulam treatment team to correspond with outside service providers with whom your child works. Please complete and sign this form.

Parent's Signature

Date