STUDENT'S NAME _____ **GRADE** _____ **DATE COMPLETED** _____

Confidential Health and Learning Profile

***This form will be used for educational planning and health purposes only. Its contents will be viewed only by your child's principal, teacher(s), and/or providers of direct or indirect special education services.**

1a. Please check the appropriate box(es) that apply to your child.

□ ADHD/ADD	□ Allergies	□ Anxiety
□ Asthma	□ Asperger's Syndrome	□ Autism/PDD
□ Conduct/Oppositional Defiant Disorder	□ Depression	□ Developmental/Cognitive Delay
□ Emotional/Behavioral Disorder	□ Diabetes	□ Epilepsy/Seizures
□ Hearing Impairment	□ Learning Disability	□ Obsessive-Compulsive Disorder
□ Physical Disability/Cerebral Palsy	□ Speech/Language Disability	□ Tourette's Syndrome
□ Visual Impairment		

1b. Does this condition/allergy impact your child's school performance or safety? . **□ Yes □ No**

Further details to help us help your child _____

_____

_____

2. Does your child have an Individual Education Plan (IEP), 504 Plan, OHD – Other Health Disability Plan, or other educational plan *from the public school district* or any formal, professional diagnosed special learning need? **□ Yes □ No**

3. Does your child have a *private school-generated* education plan providing modifications? **□ Yes □ No**

If yes to questions 1 or 2, attach a copy of your child's current educational plan (IEP, 504, or OHD) to this form.

4. Does your child receive support services in or out of their school day (special education/resource support, paraprofessional, one-on-one aide, private therapist, private tutor)? **□ Yes □ No**
If so, provide details.

_____

_____

5. Would you like us to contact you to discuss this information further? **□ Yes □ No**

6. Was a referral for assessment of concerns at school recently made or is one in progress? **□ Yes □ No**
If yes, please explain.

_____

_____

7. Does your child take medication? If yes, provide names of medication(s) and, if needed during school hours, the times administered. **□ Yes □ No**

_____

_____

8. Other information regarding your child's health or education that you would like to share.

_____

_____

_____

_____

9. I give Talmud Torah permission to share student records with my synagogue. **□ Yes □ No**

Name and relationship to child of person completing this form (please print): _____

Signature _____

Please complete and return to office, even if all no- One Per Child