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| **DESERT/MOUNTAIN SPECIAL EDUCATION LOCAL PLAN AREA****DESERT/MOUNTAIN CHARTER SPECIAL EDUCATION LOCAL PLAN AREA**17800 HIGHWAY 18 • APPLE VALLEY, CA 92307(760) 552-6700 • (760) 242-5363 FAX**Family Information** |
| **STUDENT INFORMATION** |
| Student Name: |       | Date of Birth: |       | Gender: | [ ]  Male  | [ ]  Female |
| School Site: |       | Teacher: |       |
| District of Attendance: |       | District of Residence: |       |
| Parent/Guardian: |       |
| Home Phone: |       | Work Phone: |       | Other Phone: |       |
| Street Address: |       | City: |       | State: |       | Zip Code: |       |
| Mailing Address: |       | City: |       | State: |       | Zip Code: |       |
| Language Spoken in the Home: |       |
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| **LIST SIBLINGS** |
| **Name** |  | **Gender** |  | **Age** |  | **At Home?** |
|       |  | [ ]  Male | [ ]  Female |  |       |  | [ ]  Yes [ ]  No |
|       |  | [ ]  Male | [ ]  Female |  |       |  | [ ]  Yes [ ]  No |
|       |  | [ ]  Male | [ ]  Female |  |       |  | [ ]  Yes [ ]  No |
|       |  | [ ]  Male | [ ]  Female |  |       |  | [ ]  Yes [ ]  No |
|       |  | [ ]  Male | [ ]  Female |  |       |  | [ ]  Yes [ ]  No |
| **List of Schools Child Has Attended** |
| **School** |  | **District** |  | **Type of Program** |  | **Date** |
|       |  |       |  |       |  |       |
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|       |  |       |  |       |  |       |
| **List of Hospitals, Clinics, Or Agencies That Have Examined Child** |
| **Hospital/Clinic/Agency** |  | **Address** |  | **City** |  | **State** |
|       |  |       |  |       |  |       |
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|       |  |       |  |       |  |       |
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| **GENERAL INFORMATION** |
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| 1. Briefly describe your child’s relationship with peers:
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| 1. Briefly describe your child’s relationship with brothers, sisters, and parents in the home:
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| 1. Can your child be left unattended? [ ]  Yes [ ]  No If no, please explain:
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| 1. What type of discipline does your child respond to best?
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| 1. What special interests does your child have?
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|  |
| 1. What are your major educational concerns regarding your child?
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|  |
| 1. Has your child ever been fingerprinted?
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| **PHYSICAL INFORMATION** |
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| 1. Does your child have any disabilities? [ ]  Yes [ ]  No If yes, please explain:
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|  |
| 1. Is your child now, or has he/she recently been under the care of a physician? [ ]  Yes [ ]  No If yes, please explain:
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| 1. Does your child take medication(s) for any of the following? If so, indicate frequency:
 |
|  | Seizures | [ ]  Yes | [ ]  No | If yes, indicate frequency: |       |
|  | Hyperactivity | [ ]  Yes | [ ]  No | If yes, indicate frequency: |       |
|  | Allergies | [ ]  Yes | [ ]  No | If yes, indicate frequency: |       |
|  | Diabetes | [ ]  Yes | [ ]  No | If yes, indicate frequency: |       |
|  | Thyroid | [ ]  Yes | [ ]  No | If yes, indicate frequency: |       |
|  | Asthma | [ ]  Yes | [ ]  No | If yes, indicate frequency: |       |
|  |
|  | Other:       |
|  |
| 1. Does your child normally wear any of the following? (check all that apply)
 |
|  | [ ]  Glasses | [ ]  Braces | [ ]  Hearing Aid | [ ]  Corrective Shoes | [ ]  Other: |       |
|  |
| 5. Has your child received special assistance at school? Please describe:       |
| Parent/Guardian Signature: |  | Date: |       |