Student's Name: _____

Medical Information

Please closely look at the list below and identify any that apply to your child. Please use the bottom of the page if you need more room to write.

1. Any allergies that affect his/her health? Yes ☐ No ☐
   If so, please list:

2. Any medical history that would be helpful information for us? (Premature birth, serious illness, accidents, etc.? Please list:

3. Any special needs we should be aware of? Yes ☐ No ☐
   If so, please identify:

4. Vision:
   - Wears glasses Yes ☐ No ☐
   - Has had eyes tested recently Yes ☐ No ☐ If so, when?

5. Hearing:
   - History of ear infections Yes ☐ No ☐
   - Tubes in ears Yes ☐ No ☐ If so, when was the surgery?
   - Hearing test done by an audiologist Yes ☐ No ☐ If so, when was it done?
   - Wears hearing aids Yes ☐ No ☐

6. Referred to a Speech Language Pathologist Yes ☐ No ☐
   Name of Speech language Pathologist: _____

7. Referred to an Occupational Therapist? Yes ☐ No ☐
   Name of Occupational Therapist: _____

8. Referred to an Physiotherapist? Yes ☐ No ☐
   Name of Physiotherapist: _____

9. Was seen by the SCCY Centre? Yes ☐ No ☐
   If so, when:

Student Name: _____

Brothers and Sisters (in order of age – preschool and school age)

First name/Surname	Date of Birth (Y/M/D)	School Attending