SPECIAL NEEDS QUESTIONNAIRE

STUDENT NAME: _____

Does your child currently have any of the following?

	YES	NO		YES	NO
Drug Allergies	_____	_____	Dizziness or Seizures	_____	_____
Food Allergies	_____	_____	Physical Restrictions	_____	_____
Insect Bite Allergies	_____	_____	Serious Eye Defects	_____	_____
Special Dietary Needs	_____	_____	Frequent Ear Infections	_____	_____
Asthma	_____	_____	Hearing Defects	_____	_____
Frequent Headaches	_____	_____			

If yes to any of the above, please describe:

Has your child undergone counseling? If yes, please explain in detail:

Is your child currently taking any medication? If yes, please explain in detail:

Has your child been evaluated for, found eligible for, and/or received any special education services? Yes _____ No _____

If yes, check all that apply:

_____ Learning Support
_____ Autism Support
_____ Developmental Support
_____ Speech/Language Support
_____ Hearing Impaired Support
_____ Occupational/Physical Therapy Support
_____ Emotional/Behavioral Support
_____ Visually Impaired Support

Please include evaluator and/or provider information, copies of evaluations, and any individualized plans.