

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.

- | | | |
|----------------------------------------------------------------|-----------------------------------------------------|--------------------------------------------------------|
| <input type="checkbox"/> ADHD/ADD | <input type="checkbox"/> Allergies | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Asperger's Syndrome | <input type="checkbox"/> Autism/PDD |
| <input type="checkbox"/> Conduct/Oppositional Defiant Disorder | <input type="checkbox"/> Depression | <input type="checkbox"/> Developmental/Cognitive Delay |
| <input type="checkbox"/> Emotional/Behavioral Disorder | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Epilepsy/Seizures |
| <input type="checkbox"/> Hearing Impairment | <input type="checkbox"/> Learning Disability | <input type="checkbox"/> Obsessive-Compulsive Disorder |
| <input type="checkbox"/> Physical Disability/Cerebral Palsy | <input type="checkbox"/> Speech/Language Disability | <input type="checkbox"/> Tourette's Syndrome |
| <input type="checkbox"/> 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 _____