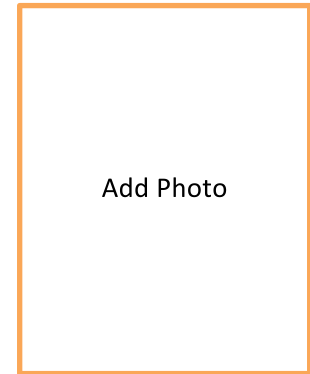
Date: 4958498we ______________

Step Together Association

Academic Year 20 ../20..



Student Data

First name: ____________________ Last name: ____________________

Gender: F ☐ M ☐ Place of birth: ________________

Date of birth: ______/____/______ Religion: ____________________

Nationality: ____________________ Home phone: ____________________

Address: __________________

Language(s) spoken: ____________

1st Emergency contact details

Family Name: ________________	First Name: ________________
Relationship to pupil: ________________	Phone: ________________

Family Data

Parents' Data	Father	Mother
Name		
Year of birth		
Nationality		
Occupation		
Mobile		
e-mail address		

Marital status of parents:

☐ Together ☐ Separated ☐ Divorced ☐ Widowed

Siblings:

Name of sibling	Gender	Age	School/ occupation	Class

Birth Order of child: ______

School History:

Year	School	Class

Medical history:

Is your child on medication? Yes ☐ No ☐

Physician's name:________________________________ Phone:______________

Medication: ________________ Dosage: _____________Frequency: __________

Medication: ________________ Dosage: _____________ Frequency: __________

Medication: ________________ Dosage: _____________ Frequency: __________

Details:

Pregnancy

____

Motor Development (sitting, walking, using hands…)

____

Verbal Development

____

Previous therapies/ treatments

____

Describe your child's current difficulties

____

Emotional Areas:

Is your child…?

Anxious	Sensitive
Responsible	Attention seeker
Shy	Easy
Quiet	Happy
Stubborn	Aggressive
Ambitious	Introvert

Describe briefly the following areas:

Diet and amount of food intake____

Type & amount of fluid intake____

Pattern of Sleep____

Mood swings____

Hands temperature____

Check below the items that the school should be aware of:

☐ Allergies ____

☐ Diabetes ____

☐ Asthma ____

☐ Epilepsy/Seizures ____

☐ Nosebleeds ____

☐ Others ____

Risk Assessment

	Yes/ No	Comments
Has the student ever gone missing from school, college or home?		
Does the student travel independently on known routes?		
Can the student cross a road on his/her own?		
Has the student ever shown aggressive or violent behavior towards others?		
Has the student caused deliberate damage to their own or others' property?		
Does the student have any self-harming behavior?		

Does the student have a history of epilepsy?		
Has the student ever been involved in injuring or causing distress to animals?		
Has the student ever taken property that does not belong to them?		
Does the student behave inappropriately around children?		
Does the student show sexual desire or behavior?		
Has the student ever swallowed something dangerous or poisonous (medication, cleaning supplies, alcoholic beverages, cosmetics…)?		

Skills Assessment

	Yes/ No	Comments
Does the student get dressed/ undressed independently?		
Does the student follow schedule, rules, and instructions?		
Does the student express his needs verbally or nonverbally?		
Does the student express his emotions (happy, angry, sad…)?		
Does the student demonstrate the ability for self-grooming (shower, brush hair, brush teeth, use deodorant, change clothes and underwear, tips for use during the menstruation period…)?		

Does the student identify money values coins and notes?		
Does the student pay for items and get change?		
Does the student read an analog or digital clock?		
Does the student read a calendar (identify day, date of week, month, year)?		
Does the student identify his/her own personal space and that of others?		

Date:____________________ Parents Signature:_____________

Please provide the school with a copy of the reports and tests carried out previously.