Brainshine

Psychological Services
STUDENT INFORMATION
(to be completed by school personnel)

Student name _____ Student goes by: _____

DOB_____ Age _____ Sex: _____ Race:_____ Grade:_____

School _____Teacher's name: _____

Teacher's email: _____

Parent information

Mother's Name : _____   Occupation: _____

Father's name   _____   Occupation: _____

Student lives with:_____

Email: _____

Phone (Mom) _____ Phone (Dad) : _____

Home Address _____

_____

Number of other children in the home: _____   Has the student repeated any grades? _____

HEARING SCREENING   VISION SCREENING   WEARS GLASSES

DATE: _____   DATE: _____   YES [ ]

RESULTS: _____   RESULTS: _____   NO [ ]

Teacher comments regarding this student's academic and behavioral functioning: _____

_____

_____

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