



Summer 2010

Charles Armstrong School, Belmont, CA

Student Information

Last Name:	_____	First Name:	_____	MI:	_____	Gender:	M ___ F ___	
Street Address:	_____		City:	_____	State:	_____	Zip Code:	_____
Date of Birth:	____/____/____	City / Country of Birth:	_____		U.S. Citizen:	Yes ___ No ___		
Primary language spoken at home:	_____	Ethnicity:	_____	Adopted:	Yes ___ No ___	Does child know:	Yes ___ No ___	
Current Grade:	_____	School Year:	_____	Grade (s) Repeated:	_____			
Present School:	_____		City / State:	_____	Public:	___	Private:	___
Name (s) and age (s) of siblings:	_____							
Does child live with both parents:	Yes ___ No ___	If no, please indicate who child lives with	_____					

Parent Information

Title:	___	Last Name:	_____	First Name:	_____	MI:	_____	
Mailing Street Address:	_____		City:	_____	State:	_____	Zip:	_____
Home Phone:	(_____) _____	Day Phone:	(_____) _____	Cell Phone:	(_____) _____			
Employer:	_____	Position:	_____	E-Mail:	_____			

Parent Information

Title:	___	Last Name:	_____	First Name:	_____	MI:	_____	
Mailing Street Address:	_____		City:	_____	State:	_____	Zip:	_____
Home Phone:	(_____) _____	Day Phone:	(_____) _____	Cell Phone:	(_____) _____			
Employer:	_____	Position:	_____	E-Mail:	_____			

Step Parent / Guardian Information (please circle)

Spouse of:

Title:	___	Last Name:	_____	First Name:	_____	MI:	_____	
Mailing Street Address:	_____		City:	_____	State:	_____	Zip:	_____
Home Phone:	(_____) _____	Day Phone:	(_____) _____	Cell Phone:	(_____) _____			
Employer:	_____	Position:	_____	E-Mail:	_____			

Step Parent / Guardian Information (please circle)

Spouse of:

Title:	___	Last Name:	_____	First Name:	_____	MI:	_____	
Mailing Street Address:	_____		City:	_____	State:	_____	Zip:	_____
Home Phone:	(_____) _____	Day Phone:	(_____) _____	Cell Phone:	(_____) _____			
Employer:	_____	Position:	_____	E-Mail:	_____			

Student Background Information

1. Has your child ever received or been evaluated for pharmaceutical therapy for: Attention Deficit Disorder (ADD): _____ or Hyperactivity (ADHD): _____
 Currently: _____ Type of therapy: _____ Pharmacological Intervention: Type: _____ Dosage: _____
2. Does your child receive treatment for allergies: _____ Type of Allergies: _____
3. Please list any outstanding medical conditions that warrant our attention (i.e. allergies, diabetes, asthma, epilepsy): _____

4. Does your child currently receive special education services? _____ Description: _____
5. Does your child have a current Individual Education Plan? _____ District of IEP: _____ Triennial Due: _____
6. Has your child received any of the following?

Type	Yes / No	Date Rec'd From – To-	Name of Clinician/Therapist, etc.	How frequently?
Lindamood Bell				
Slingerland				
Fast ForWord				
Speech and Language				
Bright Stars				
Occupational Therapy				
Psychological Counseling				
Private Tutoring				
Auditory Integration Training (AIT)				
Vision Therapy				
Other				

7. How did you hear about CAS?

	<p>Please attach a current photograph of your child:</p> <div style="border: 1px dashed black; width: 150px; height: 120px; margin: 20px auto;"></div>
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Parent's Signature

Date

Parent's Signature

Date