LONG COUNTY SCHOOL SYSTEM
Special Education Department
Background Information (Update)
(To be completed by parents or guardian)

Dear Parent: We would appreciate your help in completing this information regarding your child and returning it to the school. The information will help us in working more effectively with your child. Information on this form will be treated in a confidential manner.

Child's Name: _____ Date today: _____
First *Middle* *Last*

Address: _____ Birthdate:_____

Name of parent or guardian with whom child lives: _____ Home Phone #: _____

Agencies or specialists that have worked with this child or family:
Mental Health Clinic _____ Family Physician _____ Social Worker _____
Department of Juvenile Justice _____ Other _____

If any checked, please give the following information:

NAME	TITLE	ADDRESS	DATE SEEN
_____	_____	_____	_____
_____	_____	_____	_____

FAMILY DATA

Mother's Name: _____ Age: _____ Education: (optional) _____

Place of Work _____ Work Phone Number: _____

Father's Name: _____ Age: _____ Education: (optional) _____

Place of Work _____ Work Phone Number: _____

Step-Parent's Name: _____ Age: _____ Education: (optional) _____

Place of Work _____ Work Phone Number: _____

Marital Status of Parents: _____

If parents are separated or divorced, how old was child when the separation occurred? _____

List all people living in household:

Name:	*Relationship to Child*	*Age*
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

If any brothers or sisters are living outside the home, list their names and ages:

Name	*Age*
_____	_____
_____	_____

_____ _____

PHYSICAL CONDITION

My child's general condition is:

Seems to be in good health	Tires easily, listless, lacks energy
Overweight	Sleeps too much
Underweight	Sleeps too little
Overly active; always on the move	Awkward in running, walking, or playing

List any physical handicaps, serious illnesses, hospital stays, accidents or head injuries (vision, hearing, speech, seizures, operations, diseases, etc.) _____
_____
_____
_____
_____

Is your child on any prescription medication? Yes No If so, what? _____
_____
_____

Physician's name: _____

BEHAVIORAL CHECKLIST

(Please check the behaviors that best describe your child)

____Feels happy with him/herself
____Demands excessive attention
____Plays well with other students
____Exhibits uncooperative attitude
____Has very few close friends
____Lacks motivation, lazy
____Does not adjust readily to change
____Acts younger than other children his/her age
____Can be trusted
____Loud
____Sucks his/her thumb
____Overly dependent on others
____Overly anxious to please
____Tries to control others
____Relates well to adults
____Aggressive
____Fearful
____Openly affectionate to family members
____Restless
____Wets the bed
____Cries often
____Poor self-control
____Friendly
____Sad or depressed often
____Shy, withdrawn
____Daydreams often
____Easily frustrated
____Jealous of brother(s)sister(s)

If you wish to add additional information, please add it below or attach to this form. Thank you for your input.

_____ _____
Parent/Guardian's Signature *Date*