

**Jefferson County Schools Parent/Guardian Information**  
**(Click, Type, and Print)**

Name of Student \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Student's Address \_\_\_\_\_  
Phone (Home) \_\_\_\_\_ (Work) \_\_\_\_\_  
Emergency Contact's Name \_\_\_\_\_ Phone \_\_\_\_\_  
School Attending \_\_\_\_\_  
Previous School(s): \_\_\_\_\_  
Information Supplied by \_\_\_\_\_ Date \_\_\_\_\_

1. Please list the name and relationship to the child of all other people living in the household:
- | Name  | Age   | Relationship |
|-------|-------|--------------|
| _____ | _____ | _____        |
| _____ | _____ | _____        |
| _____ | _____ | _____        |

2. Does your child wear glasses or have a vision problem? No  Yes  If Yes, please explain:  
\_\_\_\_\_

3. Does your child have a hearing aid or a hearing problem? No  Yes  If Yes, please explain:  
\_\_\_\_\_

4. Has your child ever repeated a grade? No Yes If yes, which grade? \_\_\_\_\_

5. What academic and nonacademic concerns do you have regarding your child?

6. Has anyone in your family diagnosed with a learning disability or learning problem? No  Yes   
If yes, please explain: \_\_\_\_\_

7. How much time does your child spend on homework each night? \_\_\_\_\_

8. How much assistance do you provide during homework time? \_\_\_\_\_

9. What methods of discipline do you use at home? \_\_\_\_\_

10. Does your child have any health problems? No  Yes

11. If Yes, explain: \_\_\_\_\_

12. Does your child take any medications? No  Yes  If Yes, please list names and dosages:

Name & Dosage

13. Please list any traumatic events (deaths, divorce, injuries, etc.) that may be affecting your child's learning:

14. Birth weight \_\_\_ lbs. \_\_\_ oz Premature: No  Yes

**ON THE BACK OF THIS FORM, PLEASE LIST ANY ADDITIONAL INFORMATION THAT YOU FEEL WOULD HELP ASSIST US IN WORKING WITH YOUR CHILD.**