



Cedar Hill Preparatory Academy

Information and History Form

Student Information

Name _____ Date: _____

Date of Birth _____ Age _____ Grade _____

School(s) Attended _____

Parent/Guardian Information

Mother/Guardian _____

Father/Guardian _____

Relation _____

Relation _____

Address _____

Address _____

Personal Number _____

Personal Number _____

Email _____

Email _____

Work Number _____

Work Number _____

Occupation _____

Occupation _____

Referred By:



Cedar Hill Preparatory Academy

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Please be as detailed as possible when answering the following questions; the information is invaluable when making an individual educational plan which will be provided at the meeting set up to discuss test results.

Please list reasons for seeking assistance at Cedar Hill Preparatory Academy:



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Developmental History of Student

Developmental Milestones (speech, crawling, sitting, walking, etc.):

Ears (infections, tubes, etc.):

Vision (vision exams, diagnosis, glasses, etc.):



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Allergies (tonsillitis, seasonal, milk, sinus, etc.):

Emotional (social, domestic, trauma at school/home, etc.):

Medications (current, taken for an extended period):



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Additional comments and/or previous testing information:

Note: Please be sure that if the student wears glasses (even if not consistently) and/or is on medication, you continue these procedures for testing day.