| Student Name: | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|
| DOB: | |
| Dear School: | |
| Please detach and keep page for your records. Pages 2-3 should be mailed to the address below. | |
| The above student is being evaluated by our office. We are asking you to complete the following as we as questionnaires that are emailed to you. You will receive an invitation to fill out questionnaires throughour email. You will receive an invitation code to open the online questionnaires. Please do not try to open the link until you have the invitation code. Please return to us as soon as possible. You cooperate in completing this questionnaire is a very important part, and your comments and insights will be great appreciated. The parents/guardians should have signed the release that appears below, to exchange information. The for you to keep. Thank you for your assistance. If you have any questions or have additional information that you feel would be helpful, please feel free to call. Please send all forms to the address that appears below. Thank you | igh ion lly is is |
| PLEASE ENTER NAME OF DOCTOR . | |
| Four Seasons Pediatrics | |
| 532 Moe Road Clifton Park, NY 12065 | |
| Telephone 383-2425 | |
| PERMISSION TO EXCHANGE MEDICAL AND SCHOOL INFORMATION (FOR PATIENT'S MEDICAL RECORD) | |
| I, authorize Four Seasons Pediatrics to exchange information with (name of school) regarding ; DOB: (Stude name and date of birth) | ent |
| In order to facilitate communication between my child's school and my doctor, I hereby give permissic for sharing of medical, social, personal, and educational information relevant to the care and treatment my child's learning difficulties. | |
| I understand that my permission is required to release any information related to psychiatric and emotion health, sexual abuse, and/or drug and alcohol use, and I do grant permission for including such information if relevant in the care and treatment of my child's medical condition. | |
| I understand that the confidentiality of these records will be protected. These records cannot be disclose without written consent, except as provided for under Federal or State of New York laws. I also understand that this consent can be revoked at any time, except to the extent that action has been taken, further acknowledge that I understand the purpose of this release and consent is given of my own free very law. | . I |
| Signature and relationship of individual authorizing release Date | |

Patient Name: School Packet B DOB: ____ Date: ____ Age: ___ Grade: ___ Teacher: ____ School: _____ Phone: ____ Fax: ___ School Address: In what role, and for how long have you had contact with this student? Has this child been held back or advanced any grades? If yes, state reason: Length of attendance at your school: Frequency of absence from school: Please briefly summarize any educational testing performed on this child (or attach information) Please include IQ testing. (If testing will be done in the future, please state approximately when). Please describe briefly any problem areas you have observed in this child: How would you rate the severity of this child's problems compared to classmates of same age and sex? What procedures (if any) have been tried to change any of these concerns? Did it work? Please describe any special help or services this child is receiving at school: Briefly characterize student's relationships with peers and adults:

ACADEMIC ACHIEVEMENT (as appropriate)

| Subject Fields | N/A | Poor | Fair | Good | Excellent |
|--------------------------------|------------|-------------|-------------|--------------|--------------|
| Apparent Intelligence | _ | _ | | _ | _ |
| Penmanship | _ | _ | | _ | _ |
| Language/Art | _ | _ | _ | _ | _ |
| Reading | _ | _ | _ | _ | _ |
| Spelling | _ | | | | _ |
| Math | <u> </u> | | <u> </u> | <u> </u> | |
| Sciences | <u>—</u> | _ | | <u>—</u> | <u>—</u> |
| Social Studies | <u></u> | <u></u> | <u></u> | <u></u> | <u>_</u> |
| P.E. (recess) | | _ | | | _ |
| Please attach any cop student. | ies of CSE | and/or IEP' | s that have | been develop | ed on this |
| Any other comments | you have: | | | | |
| | | | | | |