

CHILD'S NAME: _____ DOB: _____ SITE: _____

PLEASE LIST ALL DOCTORS AND PROFESSIONALS WHO HAVE SEEN YOUR CHILD. It is important for our staff to be knowledgeable of any specialized evaluations so that these can be incorporated into your child's educational plan. Please indicate in the columns below whether we have received a report. If a report has not been sent, please indicate your consent and we will send the appropriate release for your signature to obtain a copy of the report.

TYPE of PROFESSIONAL (Please write in name.)	Tel. Number	Date last seen	Report sent to Alcott	Will send report	Will sign release
Pediatrician:					
Audiologist:					
Ear/Nose/Throat doctor: (ENT)					
Speech/Language Therapist					
Occupational Therapist:					
Physical Therapist:					
Allergist:					
Dentist:					
Neurologist:					
Ophthalmologist:					
Optometrist:					
Orthopedist:					
Physiatrist:					
Psychiatrist:					
Psychologist:					
Other: (Please specify)					

NAME of Parent/Guardian (Please Print)

Signature

Date