ACCESS
Building Brighter Futures
Schools Evaluation & Resource Center THERAPY

Today's Date:_____ Admission Date:_____

Child's Name:_____ Date of Birth: _____

Gender: _____ Race:_____ Home Phone:_____

Home Address:_____
Street City State Zip

Gestational Age: _____

Child's Diagnosis: _____

Child's Primary Care Physician:_____

Child's Social Security Number:_____

Child's Medicaid or Tefra Number:_____

Father's Name:_____Date of Birth _____
Father's Address:_____
Occupation & Employer:_____
Father's Work Number:_____
Father's Cell Number _____
Email address:_____

Mother's Name:_____ Date of Birth _____
Mother's Address:_____
Occupation & Employer:_____
Mother's Work Number:_____
Mother's Cell Number_____
Email address:_____

Emergency contact name & number:_____

Child lives with: ____Father ____ Mother ____Both parents ____ Guardian

This information is current as of the above date. I will notify the office if any changes occur. This information will be updated annually.

_____ _____
Parent/Guardian Signature date

_____ _____
Program Coordinator date

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