  
 Welcome to Progressive Child & Adolescent Gastroenterology   
**New Patient Questionnaire**

**Patient Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **D.O.B**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Sex**: 🞏M 🞏F

**Person filling out this form:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Home or Cell Phone number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Best time to contact:** 🞏AM 🞏PM

**Pediatrician:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Previous GI specialists:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**How long has this been a problem**? 🞏 2 weeks 🞏1-2 months 🞏3-4 months 🞏5-7 months 🞏10-12 month 🞏 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Previous treatments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **Duration of Use:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Symptoms: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How Long Occuring: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Other associated symptoms:**

🞏Nausea 🞏Vomiting 🞏Constipation 🞏Diarrhea 🞏Blood in stool 🞏Fever

🞏Weight loss 🞏Rash 🞏Painful urination 🞏Frequent urination 🞏Blood in urine

🞏Back pain 🞏Vaginal discharge 🞏Penile discharge 🞏 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please list your child’s current medications (including over the counter medications, vitamins, herbal remedies, birth control and holistic supplements):**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** | **Dose/Strength** | **How often?** | **Start Date** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**Does your child have any known allergies?** 🞏 No 🞏 Yes (If yes, indicate below)

|  |  |  |
| --- | --- | --- |
| **Allergy** | **Name of Food or Medication** | **What was the reaction?** |
| **Drugs**  🞏 No 🞏Yes |  |  |
| **Foods**  🞏No 🞏Yes |  |  |
| **Other** |  |  |

**Past Medical History (Check all that apply):**

**GI:** 🞏 GERD 🞏Constipation 🞏Diarrhea 🞏Pyloric Stenosis 🞏 Volvulus 🞏 Crohn’s 🞏Ulcerative Colitis 🞏Irritable Bowel Syndrome 🞏Intussusception 🞏 Excessive weight gain

**Heart:** 🞏Murmur 🞏Palpitations 🞏 Vasovagal attacks 🞏Chest pain 🞏 Kawasaki’s

**Lung:** 🞏Pneumonia 🞏 Bronchiolitis 🞏Aspiration Pneumonia 🞏 Cystic Fibrosis 🞏 Apnea

🞏 Asthma 🞏 Apparent Life Threatening Event (ALTE) 🞏 Whooping Chough 🞏 Tuberculosis

**Musculoskeletal:** 🞏Rheumatoid Arthritis 🞏Systemic Lupus Erythematosus 🞏Scleroderma

🞏 Rickets 🞏Juvenile Rheumatoid Arthritis 🞏Marfan’s Syndrome 🞏Ehlers-Danlos

🞏 Muscular dystrophy

**Neuro:** 🞏 Seizure disorders 🞏 Cerebral Palsy 🞏 Autism/Asperger’s 🞏 Autism spectrum disorder

🞏 Hydrocephalus 🞏 Meningitis 🞏Tourette syndrome 🞏 Tic 🞏Encephalitis

**Psych:** 🞏 Anxiety 🞏 Depression 🞏ADD 🞏ADHD 🞏ODD 🞏Bipolar disorder

**Endocrine:** 🞏Diabetes 🞏 Hypothyroidism 🞏Hyperthyroidism 🞏Failure to thrive 🞏GH deficiency

**🞏 Other (please. specify**) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Past Surgical History (Check all that apply):**

🞏Appendectomy 🞏Inguinal hernia repair 🞏Umbilical Hernia Repair 🞏Tympanostomy 🞏Tonsillectomy 🞏Adenoidectomy 🞏 Lacrimal duct dilation 🞏Cholecystectomy

🞏Splenectomy 🞏Congenital heart repair 🞏Diaphragmatic hernia repair

🞏Tracheo-esophageal repair 🞏Necrotizing enterocoliis surgery 🞏Orchiopexy

🞏Imperforate anus surgery 🞏Cleft lip/palate repair 🞏 Club foot repair

🞏Esophageal atresia repair 🞏Esophagomyotomy 🞏Gastrochisis repair

🞏Other (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Has your child ever been admitted to a hospital (excluding ER visit)?** 🞏 No 🞏 Yes (specify below)

|  |  |  |
| --- | --- | --- |
| **When?** | **Which hospital?** | **Reason for Admission** |
|  |  |  |
|  |  |  |

**Immunization History of your child**

🞏Up to date 🞏Delayed 🞏 Withheld (please indicate reason): 🞏 Medical reason 🞏 Personal reason

**Pregnancy History:**

Were there any complications during pregnancy in the mother? 🞏No 🞏Yes (Please check all that apply)

🞏Gestational Diabetes 🞏 Cervical incompetence 🞏 Low amniotic fluid

🞏Elevated blood pressure 🞏Polyhydramnios 🞏Pre-eclampsia

🞏Hyperemesis Gravidarum 🞏 Appendicitis 🞏 Gallstones

🞏Pre-term contractions 🞏Cholecystectomy 🞏 Placenta previa

🞏 Other (please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Birth History:**

🞏 Full-term 🞏Premature Estimated gestational age in weeks: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How was the baby delivered?

🞏 Vaginal 🞏 Vacuum/forceps assist 🞏Cesarean (Please indicate reason\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

**Baby’s birth weight \_\_\_\_\_\_\_\_\_lb \_\_\_\_\_\_\_\_\_ oz**

**Were there any complications with your baby at birth?** 🞏 No 🞏 Yes

If yes, please check all that apply.

🞏 Jaundice 🞏Difficulty in breathing 🞏 Feeding difficulties 🞏Meconium aspiration

🞏 Hypoglycemia 🞏Ventilator Use (If yes, how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) 🞏 Seizures at birth

🞏Other (please specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Was your baby in the NICU?** 🞏 No 🞏 Yes

If yes, how long was your baby in the NICU?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What was the main diagnosis? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ What was the treatment? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**When did your baby have the first bowel movement (meconium)?**

🞏24-48 hours old 🞏 48-72 hours old 🞏Greater than 72 hours 🞏Not sure

**Were any interventions were needed?** 🞏 No 🞏 Yes

If yes, what was it? 🞏 Rectal tube 🞏 Suppository

**Family history:**

Has anyone in the patient’s family had any of the following? If yes, check the box and list the relationship to the patient next to the condition.

🞏 Asthma 🞏 Childhood death 🞏 High blood pressure

🞏 Celiac disease 🞏 Crohn’s Disease 🞏 Acid reflux

🞏 Constipation 🞏 Colon Cancer 🞏 Chronic diarrhea

🞏 Hirschsprung’s Disease 🞏 Gallstones 🞏 Pancreatitis

🞏 Stomach ulcers 🞏 Irritable Bowl Syndrome 🞏 Lactose intolerance

🞏 Polyps 🞏Ulcerative Colitis 🞏 Liver Disease

🞏 Thyroid Disease 🞏 Jaundice 🞏 Hepatitis

🞏 Cirrhosis 🞏 Cystic Fibrosis 🞏 Anemia

🞏Other (Please specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Review of Systems**

**If there are any symptoms, please check the box (es).**

|  |  |  |
| --- | --- | --- |
| **General** 🞏Normal  🞏fever  🞏excessive sweating  🞏fatigue/tired  🞏exercise intolerance  🞏Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Skin** 🞏Normal  🞏eczema  🞏dry skin  🞏acne  🞏bruising  🞏hair loss  🞏itching  🞏jaundice  🞏diaper rash  🞏Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Eyes** 🞏Normal  🞏glasses  🞏contact lenses  🞏light sensitivity  🞏pink eye  🞏discharge  🞏itching of eyes  🞏Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Ears, Nose, & Throat** 🞏Normal  🞏hearing loss  🞏ear pain  🞏ear infections  🞏nose bleeds  🞏sinus infections  🞏sleep apnea  🞏trouble swallowing  🞏tooth decay  🞏mouth sores  🞏hoarseness  🞏Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Respiratory** 🞏 Normal  🞏wheezing  🞏asthma  🞏persistent coughing  🞏shortness of breath with unusual exertion  🞏shortness of breath for no reason  🞏pneumonia  🞏Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Endocrine** 🞏Normal  🞏weakness/tired  🞏hyperactive  🞏hot sensitivity  🞏cold sensitivity  🞏increased frequency or amount of urine  🞏menstrual irregularity  🞏poor growth  **-Age when periods started \_\_\_\_\_**  **-Cycles** 🞏Regular 🞏Irregular  🞏Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Urinary System** 🞏 Normal  🞏kidney failure  🞏pain/burning with urination  🞏increased frequency or amount of urine  🞏swelling/retaining water  🞏urinary tract infection  🞏bedwetting  🞏day time wetting  🞏Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Gastrointestinal** 🞏Normal  🞏trouble with bowel movement/constipation  🞏diarrhea  🞏nausea/vomiting  🞏excess weight gain  🞏weight loss, how much \_\_\_\_\_\_\_\_\_  🞏poor appetite  🞏excessive appetite  🞏gassiness  🞏burping  🞏feeling full after a small amount  🞏rectal bleeding  🞏Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Cardiovascular** 🞏Normal  🞏chest pain  🞏palpitations  🞏heart beats fast for no reason  🞏fainting  🞏heart murmur  🞏congenital heart disease  🞏heart surgery  🞏hypertension  🞏Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Musculoskeletal** 🞏Normal  🞏bone problems  🞏scoliosis  🞏joint problems  🞏muscle pain  🞏mobility issues  🞏loose joints  🞏increased flexible  🞏Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Psychology** 🞏 Normal  🞏feeling sad  🞏feels upset easily  🞏outburst of temper  🞏feels hopeless  🞏behavior issues/problems  🞏anxiety  🞏ideas of hurting self and others  If so, for how long?  If so, who?  🞏Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Neurology** 🞏Normal  🞏developmental delay  🞏headaches  🞏seizures  🞏dizziness  🞏fainting  🞏abnormal movements  🞏tremors  🞏tingling  🞏numbness  🞏decreased sensation  🞏Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Blood circulation** 🞏 Normal  🞏anemia  🞏received blood products  🞏easy bruising  🞏bleeding disorder  🞏Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Immunology** 🞏Normal  🞏Allergies  🞏Frequent infections  🞏Unusual infections  🞏swollen lymph node  🞏Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |

**Social History:**

**Who all lives with the patient at home? (Please check all that apply)**

🞏 Both parents 🞏 Mother 🞏 Father 🞏Step-father 🞏Step-mother 🞏 Foster parents

🞏Grandmother 🞏Grandfather 🞏 Sibling(s) 🞏Aunt(s) 🞏 Uncle(s) 🞏Significant other of parent

🞏 Youth Home (If yes, how long?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ what is the reason? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

**Parental Status**

🞏Married 🞏Single 🞏Divorced 🞏 Separated 🞏 Unmarried 🞏 Dual parenting

**Patient’s Sexual History**

🞏 Not applicable 🞏 Not currently sexually active 🞏 Never sexually active

🞏 Sexually active (If yes, does patient use protection? 🞏 No 🞏 Yes)

If active, how many partners? 🞏 Single 🞏Multiple

**Does the patient use alcohol?** 🞏 No 🞏 Yes (If yes, please answer the following questions).

How much does the patient drink per week? 🞏 1-2 drinks 🞏 3-4 drinks 🞏 5+ drinks

**Does the patient use tobacco?** 🞏 No 🞏 Yes (If yes please, answer the following questions).

What type of tobacco? 🞏 Cigarettes 🞏 Cigars 🞏 Chewing 🞏 Snuff 🞏Hookah

How often per week? 🞏 1-2 times 🞏 3-4 times 🞏5+ times

If the patient smokes cigarettes, how many per day?

🞏1-2 cigarettes 🞏3-4cigarettes 🞏 5-6 cigarettes 🞏half a pack 🞏 full pack

**Does the patient use marijuana?** 🞏 No 🞏 Yes (If yes please, answer the following questions).

How often per week? 🞏 1-2 times 🞏 3-4 times 🞏5+ times

**Does the patient have any pets?**

🞏 dog(s) 🞏 cat(s) 🞏 fish(es) 🞏 other (please specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Does the patient attend school?**  🞏 No 🞏 Yes (If yes, please answer the following questions).

What school grade is the patient in? **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

What type of grades does the patient get?🞏 A’s 🞏 B’s 🞏 C’s 🞏D’s 🞏F’s

If applicable, what is the patient’s GPA? \_\_\_\_\_\_\_\_\_\_\_\_\_

**Does the patient attend daycare?** 🞏 No 🞏 Yes

**What does the patient want to be when he/she grows up? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**What type(s) of sports does the patient participate in? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please list the hobbies that the patient enjoys?**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Social Neglect:**

Do you believe your child is abused or neglected in any way to your knowledge? 🞏No 🞏Yes

If yes, please explain:

**Diet History:**

|  |  |
| --- | --- |
| **If your child is an infant/toddler, please answer the following questions:** | **If your child is older than a toddler, please answer the following questions:** |
| Is your child currently being breastfed?  🞏 No 🞏Yes  If breastfed, how many feedings per day? \_\_\_\_\_\_\_\_\_\_\_  Is there supplementation with formula?  🞏No 🞏Yes  If not breastfed, what type of formula? \_\_\_\_\_\_\_\_\_\_\_\_\_\_  How frequent are feedings?  🞏2 hr 🞏3 hrs 🞏4 hrs 🞏6 hrs  Are you adding cereal to the formula? 🞏 No 🞏Yes  If yes, how many teaspoons of cereal to each bottle?  🞏1 🞏2 🞏3 🞏4 🞏5+  Other foods: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  🞏 Stage I baby food  🞏 Stage II baby food | How many servings of milk per day? \_\_\_\_\_\_\_\_\_  What type of milk? 🞏1% 🞏2% 🞏 Whole milk  How many servings of vegetables per day? \_\_\_\_\_\_\_\_\_  How many servings of fruits per day? \_\_\_\_\_\_\_\_\_    How many cups of juice per day? \_\_\_\_\_\_\_\_\_  Does your child consume spicy foods? 🞏No 🞏Yes  Does your child have diet restrictions? 🞏No 🞏Yes  If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Development:**

Based on your own understanding, is your child’s development:

🞏Normal 🞏Delayed (If yes, what is the determined developmental age? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

🞏Being investigated 🞏Other (please, specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please tell us anything else that you think may be important for us to know about your child**.

**Please let us know what your child would want to know from this visit.**

What are his/her concerns?

🞏 Fear of clinic 🞏 Fear of doctor 🞏Fear of needles 🞏Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are your concerns? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Parent Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**