



The Learning Advantage

Student: _____

Address: _____

Phone: () _____

Email: _____

Date of Birth: / / Grade: _____

School: _____

Mom: _____ Dad: _____

of siblings in home: _____

In Case of Emergency Contact:

Name: _____

Phone: () _____

Testing: *Please include dates, places and diagnosis*

Medication: *Please only include medications to treat ADHD or psychological conditions that therapist should be aware of.*

Student information is not shared with anyone without explicit written permission from parents or guardians.