



CSD
Health and Emergency Info

NOTE: Please use back of form if more space is needed

Student Name _____ DOB _____
School _____ Grade _____

Parent Names _____
Address _____
Home Phone _____ Mom Cell _____ Mom Work _____
Dad Cell _____ Dad Work _____

Emergency Contact Name _____ Home Phone _____ Cell _____
Physician's Name _____ Phone _____
Hospital Preference _____

Diagnoses (please list all) _____
Allergies _____

Medications taken at home (name, dosage, and times given) _____

Medications given at school (name, dosage, and times given) _____

PLEASE LET YOUR STUDENT'S TEACHER KNOW IN WRITING DURING THE YEAR IF THERE ARE ANY MEDICATION and/ or DIAGNOSIS CHANGES.

Diet restrictions? Yes ___ No ___ If yes, please explain _____
Activity restrictions? Yes ___ No ___ If yes, please explain _____
Walks independently? Yes ___ No ___ If no, list assistive device type _____

If your student is unable to be tested for vision or hearing at school, please provide the following:
Last private vision testing date _____ By whom? _____ Results _____
Last private hearing testing date _____ By whom? _____ Results _____

Last dental appointment date _____ Concerns? _____

Any hospitalizations, surgeries, or trips to the emergency room within last year? If so, please explain _____

Has student been seen by any medical specialists within last year? If yes, please list with brief description of results _____

Other medical information _____

NOTE: If your student has medical conditions (such as seizures, life threatening allergies, asthma, diabetes, and/or requires services such as medications at school, G-tube feedings, suctioning etc.), a separate health care plan and physician's orders are required to be updated every school year. Please contact your student's school nurse for specific instructions and required forms to be completed and in place by the first day of school.

Parent Signature

Date