

Health Information

Physical/Assistive needs: cane walker wheel chair other

Physical Restrictions: _____

Other Impairments/Medical Needs: _____

Are you currently taking medication? Yes (If yes medication form is required) No

What is the medication for? _____

Practitioner's Name: _____ Telephone: _____

The above named student is in need of the above named medication/drug during residential placement, to maintain his/her physical health. I advise and request:

That nonmedical school personnel be allowed to administer this medication/drug;

That said student is allowed to self-administer this medication/drug with the following instructions: _____

Special Meal Accommodations? Yes (If yes please provide information below) No

Food Allergies ? _____

Non Food Allergies? _____

Brief Medical History if applicable:

If parents/guardians cannot be reached in case of an accident, illness, or other **emergency**, you may contact:

Name: _____ Relationship (to child) _____ Phone: _____

Name: _____ Relationship (to child) _____ Phone: _____

If the parents or the contact persons' names above are not available, the school will call an ambulance or paramedics in a life-threatening emergency.

Preferred Hospital: _____

Insurance program and Policy number child is on: _____

Parents Signature: _____ **Date:** _____