Student Medical and Services Information

Child's Full Name ______________________________ **Entering Grade**________

Medical Information:

Does your child require medication while at school? no ☐ yes

Medications: ____

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Is your child currently diagnosed and followed by a healthcare provided for any of the following. Please check all that apply.

		yes	no
Asthma	If checked, uses inhaler?		
Seizures	If checked, on medication?		
Diabetes	If checked, insulin dependent?		

Recent illness/hospitalization/surgery (describe)____

Other, please specify ____

Severe Allergies, If checked specify type:

Food/environmental

Insect stings/bites

Medication/Drugs

Allergies require:

EpiPen

Benadryl

Other

Student Services Information:

Does your child have or had any of the following in the past? Please check all that apply.

IEP (Individual Educational Plan)

504 Plan

EP (Educational Plan)

PMP (Progress Monitoring Plan)

Other Special services

Please describe all services checked. ____

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