ACADEMY DISTRICT 20

Resource/SSN Health and Emergency Information

Student Name _____ DOB: _____
School _____ Grade: _____

Parent Names _____
Address _____
Home Phone: _____ Parent 1 Work: _____ Parent 2 Work: _____
Parent 1 Cell: _____ Parent 2 Cell: _____

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 is 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: _____