REGIONAL CAREER & TECHNICAL EDUCATION CENTER
CV-TEC
Champion Valley Educational Services
CV-TEC FOR 21ST CENTURY SKILLS

Student's Name: _____ Date of Birth: _____

Home School District: _____ Grade: _____

Address: _____ Phone #: _____

_____

Is Student Living @ Parent's Home? Yes ___ No ___ Parent/Guardian Name: _____

Daytime Phone #: _____

CV-TEC Program: _____ Teacher's Name: _____

EMERGENCY CONTACTS: (Please give relationship to student) – these persons must be willing & able to pick-up your child if necessary.

1. _____ Telephone #: _____
2. _____ Telephone #: _____

MEDICAL INFORMATION: Name of your child's primary health provider/physician: _____

1. Do you have any ALLERGIES? Yes ___ No ___ If yes, please list all allergies: _____

_____

2. Are you allergic to LATEX? _____
3. DATE OF YOUR LAST TETANUS SHOT/BOOSTER? _____
4. Do you have or ever had any of the following? (Please explain any that apply to you: Dates, details, etc.)

_____ Asthma If so, do you use an inhaler? _____

Do you carry in inhaler with you? _____

_____ Bee Sting Allergy If so, describe your reaction to stings: _____

_____

Do you need any EPI-Pen or Benadryl? _____

Do you carry medication with you? _____

_____ Hernia

_____ Diabetes If so, do you check your blood sugar at school? _____

Do you take any medication to treat your diabetes? _____

_____ Seizures If so, when was your last seizure? _____

Do you take any medication for your seizures? _____

_____ Liver Disease _____

_____ Kidney Condition _____

_____ Serious Head Injury _____

_____ Operations (please list) _____

Are you taking any medications that are NOT listed above OR do you have any other health concerns? _____

_____

DATE: _____ PARENT/GUARDIAN SIGNATURE: _____