CHAMPLAIN VALLEY EDUCATIONAL SERVICES
SPECIAL EDUCATION HEALTH OFFICE

CONFIDENTIAL STAFF MEDICAL INFORMATION
For Emergency Use Only

NAME: _____ DOB: _____
ADDRESS: _____
HOME PHONE: _____ CELL: _____
ASSIGNMENT: _____

IN CASE OF EMERGENCY CONTACT: Date Completed: _____
1. _____ AT _____
PHONE: _____ RELATIONSHIP: _____

2. _____ AT _____
PHONE: _____ RELATIONSHIP: _____

Do you have or have you ever had any of the following:

_____ Allergies: _____

_____ Asthma If so, do you use an inhaler? Yes or No
Do you carry an inhaler with you? Yes or No

_____ **Bee Sting Allergy** Describe reaction: _____
_____
Do you need an EPI-PEN or Benedryl? _____
Do you carry this medication? Yes or No

_____ **Latex Allergy** Yes or No

_____ Heart Disease Any limitations? _____
Any medications: _____

_____ Diabetes Do you check your blood sugar at work? _____ How Often? _____
Any Medications? _____

_____ Seizures What type? _____ Last Seizure? _____
Any Medications? _____

_____ Liver Disease Describe: _____

_____ Kidney Disease/Condition: _____

_____ Serious Head Injury: _____

_____ Other: _____

Medications related to your condition you are taking, please include dosage and frequency taken: _____
_____

☒ **All records will be kept confidential and inaccessible by anyone other than medical staff in the Health Office.**