Champlain Valley Educational Services
Clinton Essex Warren Washington BOCES

Student Name: _____ Date of Birth: _____

Home School District: _____ Grade: _____

Address: _____ CV-TEC Program: _____

_____ Teacher's Name: _____

Parent/Guardian Name: _____ Home Phone: _____

Parent/Guardian Address: _____ Work Phone: _____

Parent/Guardian cell phone numbers: _____ _____

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

1. _____ Telephone #: _____

2. _____ Telephone #: _____

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

Do you have any ALLERGIES? (food, medication, bee stings, insects, latex, etc.) Yes ☐ No ☐ If yes, please list: _____

_____

Do you require emergency medication for your allergy such as an EPI-PEN? Yes ☐ No ☐ Benadryl? Yes ☐ No ☐

Do you have a physician's order for this medication, and do you carry this medication with you? Yes ☐ No ☐

Do you have or ever had any of the following? CHECK ANY THAT APPLY (Please explain, add dates, etc.)

☐ Anxiety _____

☐ Asthma If so, do you use an inhaler? Yes ☐ No ☐ Do you carry your inhaler? Yes ☐ No ☐

☐ Depression _____

☐ Diabetes If so, do you check your blood sugar at school? Yes ☐ No ☐
Do you have an insulin pump? Yes ☐ No ☐ Do you have physicians' orders for Glucagon? _____

☐ Gastrointestinal Disorder _____

☐ Heart Disease/High Blood Pressure _____

☐ Seizures If so, when was your last seizure? _____ Do you take medication for your seizures? (If so, please list)

_____

☐ Serious Head Injury _____

☐ Skin Disorders _____

☐ Surgeries _____

☐ Urinary/Kidney Disorder _____

Are you taking medications that are NOT listed above OR do you have any other health concerns? Yes ☐ No ☐

_____

_____

Date: _____ Parent/Guardian Signature: _____