

HEALTH INFORMATION FORM

Student Name: _____

Parent Name & E-mail or Contact # _____

TESTING AND ACCOMODATIONS:

A: In order for us to be able to meet your/son/daughter's needs, we would appreciate having as much detailed information below as possible.

___yes ___no Does your student have any health conditions that may interfere with testing?

___yes ___no Does your student have any special needs for testing?

If yes for either of the above, please explain in detail:

B: Does your child:

___yes ___no Have an IEP on file?

___yes ___no Have a 504 on file?

MEDICAL INFORMATION:

___yes ___no Does your child have any severe allergies? _____ (list)

___yes ___no Does your child have another medical condition? _____ (list)

___yes ___no Does your child have any health issues that teachers should be aware of or that will impact your child in a classroom environment?

If yes, please explain:

Does your child carry any of these with them?

___epipen ___inhaler ___glucagon ___other medications _____ (list) ___none

Is there any other information or special circumstances your child's counselor/administrator should be aware of?

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