



**Affective Needs  
Health Emergency Info.  
2019-2020**  
Must be updated annually

**NOTE:** Please use back of form if more space is needed

Student Name \_\_\_\_\_ DOB \_\_\_\_\_  
School \_\_\_\_\_ Grade \_\_\_\_\_

Parent Names \_\_\_\_\_  
Address \_\_\_\_\_  
Home Phone \_\_\_\_\_ Mom Cell \_\_\_\_\_ Mom Work \_\_\_\_\_  
Dad Cell \_\_\_\_\_ Dad Work \_\_\_\_\_

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 IF 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