Madonna Learning Center

Current Health Information

ALL STUDENTS MUST HAVE COPY OF GREEN CARD OR IMMUNIZATION RECORD ON FILE.

(If we have a current copy of immunization record, another one does not need to be sent.)

{If exempt from immunization, please give reason: _____}

Childs Name: _____
Parents Names: _____

_____

Birthdate: _____Height_____ Weight_____
Address(es):_____

_____

_____

Home Phone: _____
Mother's Cell: _____ Mother's work: _____
Mother Email:_____
Father's Cell:_____ Father's work:_____
Father's Email:_____
Primary Care Doctor: _____
Other Physicians w/specialty

_____

_____

_____

Emergency Contact (other than Parents) Name:

_____

Contact Home Phone: _____ Cell Phone: _____
Relationship to student: _____
Diagnosis (please list all):

_____

_____

_____

Insurance Information: Name of Company: _____
Insured Name: _____
Preferred Hospital: _____
Medications: (please list all prescription and non-prescription including dosages)

_____

_____

Allergies: Yes No **Medication** Yes No **Food** Yes No **Allergic To:** _____ _____ _____	**Vision:** **Wears Glasses:** Yes No **Other**: _____ _____ _____ _____
Hearing: **Hearing Aids** Yes No **PE Tubes:** Yes No **Describe:** _____ _____ _____	**Oral Motor:** **Swallowing Problems** Yes No **Oral Defensiveness** Yes No **Describe:** _____ _____ _____
Dental: **Gum Problems:** Yes No **Teeth Problems** Yes No **Describe:** _____ _____ _____	**Heart Defects:** Yes No **Describe:** _____ _____ _____ _____ _____
Special Nutrition Concerns: **Special Diet:** Yes No **Describe:** _____ _____ _____	**Lung Problems:** Yes No **Describe:** _____ _____ _____
Diabetes: Yes No **Precautions:** _____ _____ _____ _____	**Seizures:** Yes No **Seizure Medication/Type of Medication** _____ **Precautions:** _____ _____
GI Problems: Yes No **Describe:** _____ _____	**Spinal/Bone/Joint Problems:** Yes No **Describe:** _____ _____

Hearing Loss: Yes No **Hearing Aides: Yes No** **Describe:** _____ _____ _____	**Does your child see a PT? Yes No** **Exercises recommended:** _____ _____ _____
Frequent Ear Infections Yes No **Describe:** _____ _____ _____	**Person Goals for functional skills:** _____ _____ _____ _____
Down Syndrome: Yes No **X-Ray for atlantoaxial instability Yes No** **If yes, when and what was determined?**_____ _____ _____	**Is your child free of communicable diseases? Yes No** **If no describe:** _____ _____ _____
Does your child participate in an exercise program outside of school? Yes No **Describe:** _____ _____ _____	**Personal goals for physical fitness:** _____ _____ _____ _____ _____
Physical Limits in Recess, P.E., O.T., Dance: _____ _____ _____	
Past Surgeries: Yes No **Describe:** _____ _____ _____	

Signature of Parent completing form: _____

Date: _____