Mid-Valley Special Education Cooperative

1304 Ronzheimer Avenue Saint Charles Illinois 60174 (331) 228-4873 Fax: (331) 228-4874

Serving the children and families of the Batavia, Central, Geneva, Kaneland & St. Charles Community School Districts

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Emergency and Health Information

Please provide the following information upon initial placement. For subsequent years, please update this information annually.

Student's Last Name First Name Address/City/Zip Code Home Telephone

Grade _____ Date of Birth _____ Date Entered Program _____ | Male ___ Female ____

With whom does child live? Parents ____ Mother _____ Father _____ Guardian _____

Parent/ Guardian Name _____ Mother _____ Stepmother _____ Guardian _____
Employer _____ Work Phone _____ Cell Phone _____
Email Address _____

Parent/ Guardian Name _____ Father _____ Stepfather _____ Guardian _____
Employer _____ Work Phone _____ Cell Phone _____
Email Address _____

Local emergency contact if parent or guardian is not available:

Name _____ Relationship _____ Phone _____ Cell Phone _____

Name _____ Relationship _____ Phone _____ Cell Phone _____

Please check any of the following your child uses:

Glasses _____ Contact Lenses _____ Hearing Aides _____ Dental Apparatus _____
Other _____

****I authorize this school to seek the necessary emergency care and treatment for my child whenever those individuals designated are not available.**

Yes ☐ No ☐

Signature of Parent or Guardian _____ **Date** _____

PLEASE COMPLETE NEXT PAGE

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Does your child have a formal Health Care Plan? Yes ☐ No ☐
(If yes, please attach a copy of the current plan, if available.)

Yes ☐ No ☐ Allergies: _____

Yes ☐ No ☐ Medications: (List all medications, dosage and time(s) taken)

1. _____
2. _____
3. _____
4. _____

Current Health Issues – if answering Yes to any of the following illnesses, please describe history and present status.

Asthma Yes ☐ No ☐ Explanation: _____

Diabetes Yes ☐ No ☐ Explanation: _____

Seizures Yes ☐ No ☐ Explanation: _____

Hospitalizations/Surgeries – Please list Diagnosis, Hospital, date of hospitalization.

1. _____
2. _____
3. _ _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Other Health Problems or Concerns:

_____
_____
_____
_____
_____
_____
_____
_____
_____

1. Monitoring Physician: _____ Phone: _____

2. Monitoring Physician: _____Phone: _____