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

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

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: _____

11/18/15