# *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 _____

Name _____ Mother _____ Stepmother _____ Guardian _____
Employer _____ Work Phone _____ Cell Phone _____

Name _____ Father _____ Stepfather _____ Guardian _____
Employer _____ Work Phone _____ Cell Phone _____

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☐

---

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. _____

Other Health Problems or Concerns: _____
_____
_____

1. Monitoring Physician: _____ Phone: _____

2. Monitoring Physician: _____ Phone: _____

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

10/27/14