

SPECIAL NEEDS FORM

Dear Parents,

The health office in your child's school keep a compiled list of each student's special needs or considerations. In order to serve your child to the best of our capabilities, we are asking you to please write down any pertinent information regarding your child's complete health history. A reference list is furnished at the bottom of this page for your convenience.

CHILD'S NAME _____ GRADE _____

SPECIAL CONSIDERATIONS: (Please specify the date of the onset-when it first occurred)

IF NONE, WRITE N/A AND SIGN

Parent Signature _____ DATE _____

REFERENCE LIST

- Allergies (specify to what) Example: Penicillin, food allergies
- Asthma (specify use of inhalers and/or medications)
- Dentures/Caps
- Epilepsy
- Glasses
- Hearing Deficit
- Heart Murmur (specify physical limitations)
- History of Ear Infections
- History of Strep Infections
- Nutritional Deficit (over or under weight)
- Sensitivity (specify to what)
- Surgery (specify) Example: Tonsillectomy
- Vision Deficit (other than glasses)

If your child should need to take medication in school, such as allergy inhalers, a special medication form needs to be filled out by your child's physician. Please contact the school nurse for this form.