

HEALTH INFORMATION:

Please list any information that would be necessary for us to know about your child that affects their ability to learn or participate in a classroom setting. Example: ADD, ADHD, IEP, 504, etc.

Child's name:

Child's name:

Please list any medical information that would be necessary for us to know about your child.

Child's name:

_____ Allergies _____ Asthma _____ Diabetes _____ Seizures _____ Heart
Medication _____

Child's name:

_____ Allergies _____ Asthma _____ Diabetes _____ Seizures _____ Heart
Medication _____

This information is confidential and will be kept in a separate binder in the PSR office.

PLEASE PRINT OFF AND RETURN TO THE PSR OFFICE BY May 21, 2018.