Student Name: _____ Grade: _____ DOB: _____
Last, First, MI

Our Lady of Mt. Carmel School

Special Needs Information Sheet

Parent/Guardian: _____

Address: _____ Home Phone: _____
Street

_____ Cell Phone: _____
City, State, Zip Code

Emergency Contact: _____
Name *Relationship* *Phone*

Primary Physician: _____ Phone: _____

Other Physician: _____ Phone: _____

ALLERGIES: _____
List ALL allergies to food & medication, etc.

_____

DIET: _____
Please address any dietary restrictions or special hydration needs

DIAGNOSIS/PAST PROCEDURES:

PROCEDURES TO BE COMPLETED AT SCHOOL:

Student Name: _____ Grade: _____ DOB: _____
Last, First, MI

DAILY MEDICATIONS:

Name of Medication	Dosage & Frequency	Possible Side Effects
_____	_____	_____
_____	_____	_____
_____	_____	_____

EMERGENCY PLAN:
Emergency action is necessary when the student has symptoms such as: _____

_____

_____

COMMENTS/SPECIAL INSTRUCTIONS:

_____ _____
Parent Signature *Date*

_____ _____
Physician Signature *Date*