

COMPLETE TOP OF FORM **ONLY** IF YOUR CHILD HAS A
CHRONIC HEALTH CONDITION

Please let us know if you have any questions or concerns. We will be happy to assist you any way we can.

Child's Name _____ School _____

Identified Health Concern: _____ Grade _____

Physician: _____ Phone _____

At what age was your child diagnosed? _____

Hospitalizations: _____

Surgeries: _____

Medications: _____

Food Allergies: _____

Medications to be taken at school: _____

Physical limitations: _____

Supportive equipment used: _____

Any special signs or symptoms we should be aware of: _____

How would you like them managed? _____

Students are to be potty trained prior to school starting.

Parent's Signature _____

Current EMERGENCY numbers: Home _____ Work _____

Additional EMERGENCY numbers: _____

Thank You,
Claremore Public Schools Health Services

Date Reviewed _____