CHIPPEWA VALLEY SCHOOLS
19120 Cass Avenue, Clinton Township, MI 48038
(586)-723-2000 FAX (586) 723-2001

Inspiring and empowering learners to achieve a lifetime of success

HEALTH INFORMATION

Please print or type:

Student's Name:_____ Date:_____

Birthdate:_____ Grade: 9 School Year: 2022-2023

Student's Address:_____ Phone Number:_____

Parent's Name:_____ Cell Number:_____

MEDICAL INFORMATION

MY CHILD HAS THE FOLLOWING DOCTOR DIAGNOSED MEDICAL CONCERNS. (Check all that apply)	**REQUIRED EMERGENCY SUPPLIES** (Check all that apply)
___ Asthma	___Inhaler _____
___ Diabetes	___Glucagon _____
___ Hearing/___Vision Impaired (mark those applicable)	___ Glasses/____Hearing Aide (mark those applicable)
___ Seizures	___ Emergency Medication _____
___ Allergies (i.e. Food, Latex, Insects, Medicine) Dr. Diagnosed Please list allergies: _____ _____ _____	___ Epi-pen _____

Signs to look for:

Emergency Procedures:

Other Medical Concerns:

____ My child does **NOT** have any medical concerns.

*Documentation of doctor diagnosis must be provided to the school.
*Families of children with various medical concerns may be contacted to complete an Action Plan.*Medication dispensation/medical forms for specific medical conditions can be accessed and completed by visiting this link on the website. Or http://www.chippewavalleyschools.org/for-parents/medication-forms/

I understand that this information will be kept in the office and on my child's bus (if applicable). I will update this information as my child's needs change.

Parent Signature: _____ Date: _____