ADAPTIVE P.E. STUDENT DATA FORM

TODAY'S DATE _____ DATE OF BIRTH_____

NAME _____
Last First M.I.

ADDRESS_____ CITY_____ZIP_____

HOME PHONE #_____ CELL PHONE #_____

E-MAIL ADDRESS_____

EMERGENCY CONTACT: List additional contacts on the back of this page.

NAME_____ RELATIONSHIP _____

PHONE # (work) _____ (home) _____ (cell) _____

MEDICAL CONDITIONS—DISABILITIES--DATE(S) OF ONSET (use back of page if needed):

_____

LIMITATIONS: ___BALANCE ___WALKING ___VISION ___ HEARING ___SPEECH

MOBILITY/ASSISTIVE DEVICES USED: ___WHEELCHAIR ___WALKER ___CANE ____BRACE

TRANSPORTATION TO CLASS BY: _____

CURRENT MEDICATIONS (List additional on the back). You may attach a separate sheet.

	Medication	Purpose	Dosage
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

WHERE DO YOU CARRY YOUR MEDICATIONS? _____

DIFFICULTIES RELATED TO YOUR MEDICATIONS_____

ALLERGIES_____ HAVE YOU EVER HAD A SEIZURE? _____

PRIMARY DOCTOR'S NAME_____ PHONE # _____

ADDRESS_____ CITY_____ ZIP_____
List additional doctors on the back of this page.

HOSPITAL OF CHOICE_____ HEALTH INSURANCE_____ KAISER I.D.#_____

I understand and agree with my Student Responsibilities for participation in this program.

Signature **Date**