

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.

<u>Medication</u>	<u>Purpose</u>	<u>Dosage</u>
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.# _____

