ADAPTIVE P.E. STUDENT DATA FORM

Today's Date: _____ Date of Birth: _____

Name: _____
Last First M.I.

Street Address: _____ City: _____ Zip: _____

Home Phone # _____ Cell Phone: _____

Email: _____

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

Name: _____ Relationship: _____

Work Phone: _____ Cell Phone: _____ Home Phone: _____

MEDICAL CONDITIONS-DISABILITIES	**Date of Onset (use back of page if needed)**

LIMITATIONS: ☐ Balance ☐ Walking ☐ Vision ☐ Hearing ☐ Speech

Mobility/Assistive Devices Used: ☐ Wheelchair ☐ Walker ☐ Cane ☐ Brace

Transportaion to class by: _____

CURRENT MEDICATIONS: (List additional on the back. If necessary, attach a separate sheet).

Medication	**Purpose**	**Dosage**

Where do you carry your medications: _____

Difficulties related to your medications: _____

Allergies: _____ Have you ever had a seizure? ◯ Yes ◯ No

Primary Doctor's Name: _____ Phone: _____

Doctor's address: _____ City: _____ Zip: _____
List additional doctors on the back of this page.

Hospital of Choice: _____

Health Insurance: _____ ID #: _____

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

Signature: _____ Date: _____