Madison Metropolitan School District

Doyle Administration Building
545 West Dayton Street
Madison, WI 53703-1995

Health Services

PARENT LETTER: SPECIAL NEEDS INFORMATION
(Return this form to the Health Office at your child's school as soon as possible.)

Date: ____________________ School/Grade: ________________________

Dear Parent/Guardian:

In an effort to provide a safe, healthy environment for __________________________ Student Number __________________ at school, we would like to know about your child's health needs. Please complete the following information. Thank you!

____
School Nurse/Phone Number

1. What are your child's health concerns/medical diagnoses? Please describe.

2. What medication (prescription and non-prescription) does your child take? Please include any medications your child takes both at home and at school.

Medication Name	**Strength/Dose**	**Frequency**	**Purpose**

3. List any medical problems or emergencies your child could develop at school. Indicate how you would like them managed at school.

4. Describe any health problems that occurred over the summer.

5. How does your child communicate discomfort/illness?

6. List any hospitalizations or surgeries your child had in the last year.

7. Please list any immunizations your child received over the summer.

8. Bathroom
   Is your child toilet trained? Day_____ Night_____
   Describe any assistance your child requires with bathrooming needs.

9. Nutritional Needs
   List any food allergies/sensitivities/intolerances.

   Describe any special diet/equipment/procedures required for feeding.

10. Activity needs
Describe any activity restrictions due to health concerns. **Physician's note is required for gym limitations.**

Currently, does your child rest during the day? Yes ____ No____
If yes, time of day?

Does your child require special equipment, adaptations at school (e.g., wheelchair, braces, etc.)?

11. Vision
In the last year, has your child had his/her vision checked? Yes ____ No____
If there was a problem, describe.

12. Hearing
In the last year, has your child has his/her hearing checked? Yes ____ No_____
Explain the results.

13. Does your child have a seizure disorder? Yes ____ No____
If so, please describe type of seizure and how often seizures occur.

14. Does your child have asthma, allergies or hay fever? Yes ____ No____
If yes, please describe signs and frequency of problems.

15. Who are your child's health care providers?

Family Physician ______________________________

Specialist ______________________________

Public Health Nurse ______________________________

Other (ex: OT, PT, Speech & Language) ______________________________

16. May this information be shared with appropriate school personnel, as determined by the school nurse? Yes ____ No____

17. May this information be included on a health concern list that is maintained in the school health office? Yes ____ No____

______________________________ Signature of Parent/Legal Guardian

______________________________ Date

Home Phone:______________________________ Work Phone:______________________________