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____

Screenshot