APPLICATION FOR ADMISSIONS

Student Health Information

Today's Date: ______________________

Student's Name: ______________________

Date of Birth: ______________ Grade: ____________

Primary Care Provider: ______________________ Phone: __________

Dentist: ______________________ Phone: __________

Therapists:

Speech-Language Pathologist: ______________________ Phone: __________

Occupational Therapist: ______________________ Phone: __________

Physical Therapist: ______________________ Phone: __________

Psychiatrist: ______________________ Phone: __________

Other: ______________________ Phone: __________

Does your child have any of the following medical conditions? Yes/No

Allergy: ☐ Yes ☐ No

If yes, describe trigger (s) and treatment: ______________________

Asthma: ☐ Yes ☐ No

If yes, describe trigger(s), symptoms, medications: ______________________

Diabetes: ☐ Yes ☐ No

If yes, date of onset: ______________________

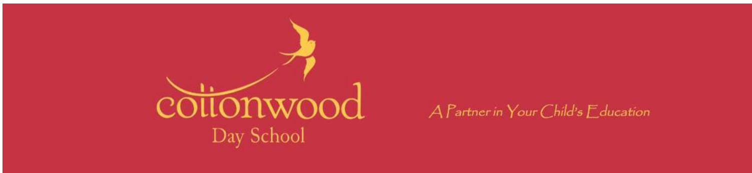
Seizures: ☐ Yes ☐ No

If yes, describe type and treatment: ______________________

ADHD: ☐ Yes ☐ No

If yes, list medication(s): ______________________

Non-discrimination Policy: COTTONWOOD DAY SCHOOL admits students of any race, color, national and ethnic origin to all the rights, privileges, programs, and activities generally accorded or made available to students of the school. It does not discriminate on the basis of race, color, national or ethnic origin in administration of its admission/educational policies, financial aid programs, and other school-administered programs.



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Student Health Information

Vision Problems: ☐ Yes ☐ No

If yes, glasses or contacts: ______________________________

Hearing problems: ☐ Yes ☐ No

If yes, please explain: ______________________________

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Toilet Issues: ☐ Yes ☐ No

If yes, please explain: ______________________________

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Other: ☐ Yes ☐ No

If yes, please explain: ______________________________

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Special diet or food restrictions: ☐ Yes ☐ No

If yes, please explain: ______________________________

____

Is your child taking any medications regularly: ☐ Yes ☐ No

If yes, please list: ______________________________

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Please note: Please note: Any child requiring prescription medication at school will need a health care plan and a doctor's order on file before this medication can be administered by an authorized staff member.

Do you have any educational or behavioral concerns about your child? ☐ Yes ☐ No

If yes, please describe ______________________________

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