

School Year \_\_\_\_\_

**CARMEL CLAY SCHOOLS**  
**5201 E. Main St. · Carmel, IN 46033 · (317) 844-9961**

**SPECIAL NEEDS INFORMATION SHEET**

Name \_\_\_\_\_ Grade \_\_\_\_\_ D.O.B. \_\_\_\_\_  
Last Name First MI

Parent/Guardian \_\_\_\_\_

Address \_\_\_\_\_ Phone (home) \_\_\_\_\_

Phone (work - Mom) \_\_\_\_\_ Phone (work - Dad) \_\_\_\_\_

Phone (cell - Mom) \_\_\_\_\_ Phone (cell - Dad) \_\_\_\_\_

Emergency Contact \_\_\_\_\_  
Name Relationship Phone

Primary Physician \_\_\_\_\_  
Phone

Other Physician \_\_\_\_\_  
Phone

ALLERGIES \_\_\_\_\_  
Food, Medication, etc.

DIET \_\_\_\_\_  
Please address any dietary restrictions or special hydration needs

**DIAGNOSIS/PAST PROCEDURES**

1. \_\_\_\_\_  
\_\_\_\_\_

2. \_\_\_\_\_  
\_\_\_\_\_

3. \_\_\_\_\_  
\_\_\_\_\_

(over)

PROCEDURES TO BE COMPLETED AT SCHOOL

1. \_\_\_\_\_  
\_\_\_\_\_

2. \_\_\_\_\_  
\_\_\_\_\_

DAILY MEDICATIONS

Name of Medication	Dosage and Frequency	Possible Side Effects
_____	_____	_____
_____	_____	_____
_____	_____	_____

EMERGENCY PLAN

Emergency action is necessary when the student has symptoms such as \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

COMMENTS/SPECIAL INSTRUCTIONS

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Physician Signature Date

I give permission for the school nurse and any pertinent staff caring for my child to follow this plan, administer medication and care for my child, contact my care provider if necessary and for this form to be faxed/emailed to my child’s school or be shared with school staff per FERPA guidelines. I assume full responsibility for providing the school with prescribed medication and delivery/monitoring devices.

\_\_\_\_\_  
Parent Signature Date