

Concordia Learning Center at St. Joseph's School for the Blind
761 Summit Avenue
Jersey City, NJ 07307

STUDENT MEDICAL PROFILE

Student's Name: _____

Parent's/Guardian's Name: _____

Address: _____

Home Phone Number: _____

Work Phone Number: _____

Parent's/Guardian's E-mail: _____

Alternate Responsible Person: _____

Relationship: _____

Telephone Number: _____

MEDICAL INFORMATION

Name of Attending Physician: _____

Telephone Number: _____

Name of Attending Dentist: _____

Telephone Number: _____

ALLERGIES TO MEDICATION OR FOOD:

DIETS:

SEIZURE PRONE: YES NO **DATE OF LAST SEIZURE:** _____

MEDICATIONS:

SAFETY EQUIPMENT: _____ **HEARING AID:** Left Right Both

MOBILITY AIDES:

V.P. Shunt: Left Right

Eye Prosthesis: Left Right Both

Prescription Glasses: Yes No

Date of Last PPD (Tuberculin) test: _____

Date of last DT (Booster): _____

ADDITIONAL MEDICAL INFORMATION OR COMMENTS:

