SADDLEBACK VALLEY UNIFIED SCHOOL DISTRICT
Adult Transition Program

PHYSICAL INFORMATION DATA

2021-22 School Year

Student name: _____

Is your student conserved? ____Yes ____ No

Has your student ever experienced a seizure or series of seizures? _____
Date of last seizure: _____

Does your student presently experience any type of epileptic seizure? _____
Are these seizures being controlled by medication? _____

What action should the teacher take at school if a seizure occurs there? _____
_____

Has your student ever had an allergic reaction? _____
Please describe any special treatment he/she may require:
_____

Please list any medication your student may be taking presently **at home or at school**, with the requested information:

Medication name	Dosage	Times given	Reason given

Does your student suffer from any heart condition, which may limit his/her activity or which may result in an emergency condition at school? _____

Does your student suffer from frequent infections? _____

Please list any eye or ear conditions/defects which require special consideration? _____
_____

Has your daughter started her menstrual cycle? _____
If yes, does she experience cramps or prolonged duration of menstrual flow? _____
Has she been taught menstrual hygiene? _____

OTHER HEALTH COMMENTS: _____
_____

_____
Parent/guardian signature Date