SPECIAL MEDICAL NEEDS FORM
(Asthma, etc.)

(For allergies, please fill out Allergy Treatment Plan only. For Asthma, please also fill out Asthma Treatment Plan)

Last Name: ___________________ First Name: ____________________

Grade _____________ D.O.B. _______________

Physician Student sees for this condition: _____________________ Phone: _______________________

Other Physician: _____________________________________ Phone: _______________________

MEDICAL SITUATION
Diagnosis:
Brief description of how this condition can affect your child and how we can be of assistance:
Activity Restrictions:
Currently taking Medication: ☐ Yes ☐ No Medication Regimen (including medication not usually given in school):

If your child may need medication, please fill out the section below. Please ensure that the office has an updated (and not expired) supply of all the medication/equipment **DUE AT TIME OF ADMISSIONS**. If the child will be administering the medication himself, please fill out *Request for Self Administration of Medication Form*.

AUTHORIZATION TO ADMINISTER MEDICATION IN SCHOOL		
Symptoms that require medication:		
Medication:	Dose:	How often:
	Purpose of Drug:	Possible Side Effects:
Medication:	Dose:	How often:
	Purpose of Drug:	Possible Side Effects:

____________________________ ____________________________
Parent/Guardian Signature Date

____________________________ ____________________________
Physician's Signature Date

1333 BROAD STREET ❖ CLIFTON, NJ 07013 ❖ 973-472-0011 ❖ ADMIN@CLIFTONCHEDER.ORG ❖ FAX: 866-518-5682