ST. VINCENT'S SPECIAL NEEDS SERVICES/STUDENT INFORMATION

MEDICAL INFORMATION UPDATE FORM

Student's Name: _____ Date: _____

IMMUNIZATIONS RECEIVED IN PAST 18 MONTHS: _____

Date of Last Tetanus Booster: _____

Please list all allergies:

FOOD: _____ Insect bites: _____

MEDICATION: _____Environmental: _____

HOSPITALIZATIONS, INCLUDING OPERATIONS WITHIN THE LAST 18 MONTHS

DATE	HOSPITAL	DOCTOR	REASON

PLEASE LIST TESTING DONE IN THE LAST 18 MONTHS

TEST	DATE	WHERE PERFORMED	DOCTOR
Cat Scan/MRI			
EEG			
Hearing Test/Type			
Vision Test/Type			
Any genetic screening, type if known			
Other:			

MEDICATION LIST

PLEASE LIST ALL CURRENT MEDICATIONS BEING TAKEN:

MEDICATION	DOSAGE	TIME(S) ADMINISTERED