

**Counseling Department
Information Sheet**

Student Name: _____

Please only include medical/mental health/family related information as it applies to your student's school day/school performance. Information regarding seasonal allergies, etc. is not necessary. Thank you.

Emergency Contacts:

Name/#: _____

Name/#: _____

Medical Diagnosis: _____

Medication: _____

School History of an IEP or 504 Plan? Yes_____ No_____

Additional Information: _____

Food/Medication Allergies: _____

Mental Health/Learning Disorder Diagnosis: _____

Medication: _____

Additional Information: _____

Family Information that may impact learning: _____

Parent Signature: _____

Please return this with your registration information.

All information remains in the Guidance Office and is shared only on an as needed basis with administration and teachers. Questions may be directed to Bill Letton, Director of Guidance at (859)277-7183 ext. 224.

Grade Level (Next Fall) _____