

Grade Level (Next Fall) _____

**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.