CAÑADA COLLEGE ADAPTIVE P.E. STUDENT DATA FORM

DATE ______________________ STUDENT I.D. # (will be assigned)_________________________

NAME ____
Last First M.I.

ADDRESS_____________________________________ CITY_____________________ ZIP________

HOME PHONE #_____________________________________ BIRTHDATE____________________

EMERGENCY CONTACT:

NAME____ RELATIONSHIP__________________

PHONE # (work) ____________________________ (home) ___________________________________

MEDICAL CONDITIONS—DISABILITIES--DATE(S) OF ONSET (use back of page if needed):

____

LIMITATIONS: ___BALANCE ___SPEECH ___WALKING ___VISION ___OTHER___________

MOBILITY/ASSISTIVE DEVICES USED: ___WHEELCHAIR ___WALKER ___CANE ____BRACE

TRANSPORTATION TO CLASS BY: ____

CURRENT MEDICATIONS (List additional on the back). You may attach a separate sheet.

Medication	Purpose	Dosage
1. ____________________________________	______________________________	____________
2. ____________________________________	______________________________	____________
3. ____________________________________	______________________________	____________

WHERE DO YOU CARRY YOUR MEDICATIONS? ____

DIFFICULTIES RELATED TO YOUR MEDICATIONS_______________________________________

ALLERGIES_____________________________ HAVE YOU EVER HAD A SEIZURE? __________

PRIMARY DOCTOR'S NAME________________________________ PHONE # _______________

ADDRESS_____________________________________ CITY_____________________ ZIP________
List additional doctors on the back of this page.

HOSPITAL OF CHOICE?_____________ HEALTH INSURANCE__________ KAISER I.D.#_______

WHAT DO YOU WISH TO ACHIEVE THROUGH PARTICIPATION IN THIS PROGRAM?

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ADDITIONAL PHYSICIAN NAMES & ADDRESSES:

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ADDITIONAL MEDICATIONS & DOSAGES:

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The above information (front & back side of this sheet) has been provided voluntarily by the under-signed, who is solely responsible for its accuracy and updating.

____________________________ ____________________________
SIGNATURE DATE