

Referral for Career Assessment

Student Information:

Diabetes

Other

name:								IVI	ember Scr	1001:	
Address:								Da	te of Birth	า:	
Email:								Cu	rrent Gra	de:	
Phone Numbe	er:										
Parent/Guard	ian Info	rmation:									
Student Lives		oth Parents	Both	Parents/Separ	rate A	ddresses	Mothe	r Only	Father C	nly	Legal Guardian(s)
(X one)											
Name:								Relatio	nship:		
Address (if diff	ferent th	an student's	s):						•		
Email:											
Home Phone:			(Cell Phone:			Wor	Work Phone:			
			·								
Name:								Relatio	nship:		
Address (if diff	ferent th	an student's	s):								
Email:											
Home Phone:			(Cell Phone:				Wor	k Phone:		
for this, pleas	se provi	de the follo	owing	_	n:						o help us prepar esponses.
Condition	X If ye	s Expl	lain			Co	ndition	X If y	es	Expla	nin
ADHD						Epilepsy					
Allergies						Fainting S	Spells				
Asthma						Severe H	eadache	s			
Back Problems						Hearing I	_OSS				

Vision Problems

Glasses/Contacts*

Wears

^{*}If yes, please bring to the assessment

If your child is taking medication	, please fill in the following:
------------------------------------	---------------------------------

Medication:	Administered d	uring the school day:	For treatment of:
your opinion, does yo chnical training progra		r medical concerns w	hich may limit him/her in a career-
Yes If Yes, plea	ase explain:		
No	·		
losso indicate the best t	ime for any future meetings o	r conformes botwood	2.00 a m and 2.00 n m :
rease mulcate the best t	line for any future meetings of	r conferences between	1 8:00 a.m. and 3:00 p.m.:
the event of an emer		-	e reached, I grant permission for m
the event of an emer	gency and I or my emergen	-	e reached, I grant permission for m
the event of an emer on/daughter to receive	gency and I or my emergence emergency treatment at the	he nearest hospital.	e reached, I grant permission for mover the reached authorities to take the
the event of an emer on/daughter to receive If no: In the event of an il following action:	gency and I or my emergence emergency treatment at the	No gency treatment, I requ	e reached, I grant permission for mo
the event of an emer on/daughter to receive f no: In the event of an il following action:	gency and I or my emergence emergency treatment at the Yes	No gency treatment, I require cannot be reached:	
on the event of an emer con/daughter to receive on/daughter to receive on/daughter to receive on/daughter to receive on illing action:	gency and I or my emergence emergency treatment at the Yes	No gency treatment, I require cannot be reached:	uest school authorities to take the
on/daughter to receive	gency and I or my emergence emergency treatment at the Yes	No gency treatment, I require cannot be reached:	uest school authorities to take the

Parent /Guardian Signature Student Signature Date