CENTER FOR SPECTRUM SERVICES
Brightening the lives of people with autism

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2022 – 2023 SCHOOL YEAR
Student Questionnaire in Case of a Medical Emergency or Elopement

Student: _____ (Nickname):_____ D.O.B. _____

Mother/Legal Guardian	**Father/Legal Guardian:**
Address:	**Address: (if different)**
Home Phone #:	**Home Phone #:**
Cell #:	**Cell #:**
E-mail:	**E-mail:**
Place of Employment:	**Place of Employment:**
Work #:	**Work #:**

Daycare Provider:_____ Phone: _____

Street Address:_____ Days/Times: _____

OPWDD Eligible – YES / NO TABS # _____

EMERGENCY CONTACT INFORMATION: ***(2 names are required)***

In the event my child becomes ill and I cannot be reached, I authorize the following people to be called and pick up my child from school. If this contact list changes, I will immediately notify the school.

Name_____Relationship_____ Cell # _____
Home #_____
Work # _____

Name_____Relationship_____ Cell # _____
Home #_____
Work # _____

Contact Restrictions: Is there an Order of Protection or are there legal restrictions prohibiting contact against anyone? Yes_____ No_____ If yes, who: _____

I hereby give permission and voluntarily consent to any of the Emergency Room physicians, qualified personnel, or staff of a duly licensed hospital, or any duly licensed physician or dentist in the State of New York to administer anesthetics and perform such diagnostic treatment or medical or operative procedures, including transfusions, upon my listed child, as may be deemed necessary.

_____ _____
Parent/Guardian Signature Date

PLEASE COMPLETE BOTH SIDES OF THIS FORM

MEDICAL / ELOPEMENT ALERT INFORMATION

IT IS NECESSARY THAT THIS INFORMATION BE CURRENT.
PLEASE INFORM CENTER FOR SPECTRUM SERVICES OF ANY CHANGES DURING THE SCHOOL YEAR.

Student Name _____ Date of Birth_____Sex:_____

Height_____Weight_____Hair Color_____Eye Color_____Glasses_____Hearing Aides_____
Does child wear: _____ID card ____Medical Alert Tag ____Tracking Device ____Other?
Identifying marks/scars_____

Medical Diagnosis _____

Primary Care Physician_____
Address_____Phone_____

Other Medical Specialists _____
Address_____Phone_____

Date of last Tetanus Vaccine _____

My child takes the following medications on a routine basis

Medication	Dose	Times given	Purpose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Has your child had any of the following (please check all that apply)

___ History of seizure activity:
Type_____ Frequency_____
Treatment_____
Is child currently seizure active? _____Last known seizure _____

____Significant allergies
Food allergies requiring special diet_____Food sensitivities_____
Medication allergies_____Environmental _____
Other _____

____ Asthma or chronic upper respiratory difficulties

IMPORTANT INFORMATION (Please check all that apply)

___no sense of danger ____hearing impaired ___vision impaired
___communication delay ____ non-verbal ___poor response to language
___does not respond to name ____does not respond to inhibitory words (no, stop, come here)
___uses a communication device ____ sensory concerns ___significant fears
____Favorite toys, objects, music: _____
___other important information _____
_____
Has the child wandered off before? _____ Places the individual may wander to_____
Water sources_____
Friends /neighbors_____
Hiding spots_____
other_____
Unusual behaviors or characteristics that may attract attention _____
Additional Information: _____

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