LarcSchool

Health Office Update

Your child's records are updated yearly. The following information is necessary. Please complete and return as soon as possible.

Student Name____Age____________

1. Is your child registered with:

	Yes	No
Perform Care (previously DDD)		
Special Child Health		
Commission for the Blind		

2. Insurance Information:

	Yes	No	If yes, Name:
Private Insurance			
Medicaid			#
Medicaid Managed Care			#
No Insurance Coverage			

3. Who is your child's:

Pediatrician	
Eye Doctor	
Orthopedic Doctor	
Neurologist	
Dentist	
Equipment Vendor	
Other	

4. What is your hospital of choice in case of emergency?

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5. Does your child have a medical diagnosis?

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6. Any changes or concerns?

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