

Texas School for the Blind and Visually Impaired

Medical Dietary History

Student's Name: \_\_\_\_\_

Gender: \_\_\_\_\_

Student's Date of Birth: \_\_\_\_\_

Today's Date: \_\_\_\_\_

It is important for us to have complete information about each student's medical conditions and dietary information. Please provide complete and specific information on every question. This form is required of every student without exception, even if the student already attended TSBVI at an earlier time. Thank you for your patience and thoroughness!

Recent Hospitalizations

Has student been hospitalized during the last 12 months?  Yes  No

If yes, describe below:

[Empty text box for describing hospitalizations]

Medications

Does student regularly take prescription or over-the-counter medications?  Yes  No

If student does take medication: Take the "Health Care Provider's Order for Student Medication" form to the student's physician's office and have one of the approved staff listed on the form complete and sign the form.

Eyes

Describe student's eye condition, including when it began or when you became aware of it, and how student is affected by the vision loss, to the best of your knowledge.

Example 1: Student has retinitis pigmentosa. Student began to lose his vision at age 16. He has lost most of his vision but still has some central vision.

Example 2: I do not know the cause of Student's vision problems. She seems to see some light.

[Empty text box for describing eye condition]

Student has glasses.  Yes  No

Student has contact lenses.  Yes  No

If yes, which eye(s):  Right Eye  Left Eye

Does student need assistance with contact care?  Yes  No

If yes, describe below:

[Empty text box for describing contact care assistance]

Student has prosthetic (artificial) eyes.  Yes  No

If yes, which eye(s):  Right Eye  Left Eye

Does student need assistance with prosthetic care?  Yes  No

If yes, describe below:

Does student have an Aqueous (Ocular) shunt? Yes  No

If yes, which side is the shunt located?  Right  Left

If yes, explain below. Describe complications, long-term effects, ongoing treatment or other important information.

**Does student have any of the following eye conditions? (check all that apply)**

- Retinopathy of Prematurity (with functional vision, i.e. more than just light perception)
- Coloboma (bilateral)
- High myopia
- Toxoplasmosis
- Posterior vitreous detachment
- Diabetic Retinopathy
- Glaucoma (TSBVI places retinal precaution if student is using pilocarpine eye drops, or if the Glaucoma is related to Diabetes, or if retinal precaution is indicated by student's eye doctor)
- Uveitis - chronic eye infection
- Marfan syndrome
- CHARGE syndrome
- Any history of retinal detachment
- X-Linked Juvenile Retinoschisis
- Coats Disease

The above eye conditions are associated with increased risk of retinal detachment. To ensure student's safety, TSBVI places the following retinal precautions for students with one or more of these conditions.

"Student is at risk for retinal detachment. Student may not participate in activities likely to cause a blow or jarring to the head. Such activities include, but are not limited to, cheerleading, trampoline, jumping rope, gymnastics, water or snow skiing, contact sports (such as soccer, football, martial arts, basketball, or wrestling), and sports with flying projectiles (such as goal ball, tennis, baseball, volleyball or softball). Student may not dive headfirst into a pool or body of water. Staff should notify the Health Center immediately if student complains of sudden changes in vision, seeing flashes, an increase or development of floaters, or any other changes in peripheral vision."

**Describe any additional precautions TSBVI staff needs to take because of student's visual problem:**

**Ear**

**Student has none of the following conditions.**

Type of Problem	If Yes, explain. Describe complications, long-term effects, ongoing treatment or other important information.
Hearing Problem <input type="checkbox"/> Yes <input type="checkbox"/> No	
Hearing Aids <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, which ear(s)? <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both Does student need assistance with care of aids? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, explain:
Cochlear Implants <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, which ear(s)? <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both Does student need assistance with cochlear implants? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, explain:
Frequent Ear Infections <input type="checkbox"/> Yes <input type="checkbox"/> No	
Ear Tubes <input type="checkbox"/> Yes <input type="checkbox"/> No	
Other:	

**Sleep Patterns**

**Does the student have difficulties with sleep (for example, difficulty falling asleep, waking during the night)?**

**Yes**  **No**      **If yes, explain:**

### Behavioral, Psychological

Student has none of the following conditions.

**Has the student had any of the following conditions? (check all that apply)**

Attention Deficit Disorder (ADD) or (ADHD)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Autism	<input type="checkbox"/> Yes <input type="checkbox"/> No
Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No	Bipolar Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anxiety / Panic attacks	<input type="checkbox"/> Yes <input type="checkbox"/> No	Obsessive Compulsive Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
Post-Traumatic Stress Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Suicidal Ideation / Behaviors	<input type="checkbox"/> Yes <input type="checkbox"/> No
Conduct disorder (aggressive, destructive, or deceitful behaviors)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Verbal Aggression	<input type="checkbox"/> Yes <input type="checkbox"/> No
Physical Aggression	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychotic disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hallucinations	<input type="checkbox"/> Yes <input type="checkbox"/> No	Alcohol / Substance abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No

Other:

**If you selected Yes to any of the above conditions, explain. Include ongoing medication, treatment or other important supportive information.**

### Diseases (Past and Current)

Name of Disease	Has student had the disease?	If Yes, explain. Describe complications, long-term effects, ongoing treatment or other important information.
HIV	<input type="checkbox"/> Yes; Year: _____ <input type="checkbox"/> No	
AIDS	<input type="checkbox"/> Yes; Year: _____ <input type="checkbox"/> No	
COVID-19	<input type="checkbox"/> Yes; Date: _____ <input type="checkbox"/> No	
Cytomegalovirus (CMV)	<input type="checkbox"/> Yes; Year: _____ <input type="checkbox"/> No	
Hepatitis A	<input type="checkbox"/> Yes; Year: _____ <input type="checkbox"/> No	
Hepatitis B	<input type="checkbox"/> Yes; Year: _____ <input type="checkbox"/> No	
Hepatitis C	<input type="checkbox"/> Yes; Year: _____ <input type="checkbox"/> No	
Hepatitis (other form):	<input type="checkbox"/> Yes; Year: _____ <input type="checkbox"/> No	
Tuberculosis	<input type="checkbox"/> Yes; Year: _____ <input type="checkbox"/> No	

### Gastrointestinal

Student has none of the following conditions.

Type of Problem	If Yes, explain. Describe complications, long-term effects, ongoing treatment or other important information (for example, Colostomy, Ileostomy).
Frequent Diarrhea <input type="checkbox"/> Yes <input type="checkbox"/> No	
Frequent Constipation <input type="checkbox"/> Yes <input type="checkbox"/> No	
Recurring Hemorrhoids <input type="checkbox"/> Yes <input type="checkbox"/> No	
Encopresis (involuntary bowel movement) <input type="checkbox"/> Yes <input type="checkbox"/> No	
Other:	

### Respiratory

Student has none of the following conditions.

Type of Problem	If Yes, explain. Describe complications, long-term effects, ongoing treatment or other important information (for example, Tracheotomy, Respirator).
Frequent Colds <input type="checkbox"/> Yes <input type="checkbox"/> No	
Pneumonia <input type="checkbox"/> Yes <input type="checkbox"/> No	
Bronchitis <input type="checkbox"/> Yes <input type="checkbox"/> No	
Asthma or Reactive Airway Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Does student have an emergency inhaler?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
Cystic Fibrosis <input type="checkbox"/> Yes <input type="checkbox"/> No	
Sleep Apnea <input type="checkbox"/> Yes <input type="checkbox"/> No	
Other:	

### Blood, Heart, Circulatory

Student has none of the following conditions.

Type of Problem	If Yes, explain. Describe complications, long-term effects, ongoing treatment or other important information (for example, Stint, Pacemaker).
Prolonged Bleeding or Hemophilia <input type="checkbox"/> Yes <input type="checkbox"/> No	
Bruises Easily <input type="checkbox"/> Yes <input type="checkbox"/> No	
Heart Problem <input type="checkbox"/> Yes <input type="checkbox"/> No	
Hypertension <input type="checkbox"/> Yes <input type="checkbox"/> No	
Sickle Cell Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	
Other:	

### Endocrine

Student has none of the following conditions.

Type of Problem	If Yes, explain. Describe complications, long-term effects, ongoing treatment or other important information.
Hyperthyroidism <input type="checkbox"/> Yes <input type="checkbox"/> No	
Hypothyroidism <input type="checkbox"/> Yes <input type="checkbox"/> No	
Hypopituitarism <input type="checkbox"/> Yes <input type="checkbox"/> No	
Panhypopituitarism <input type="checkbox"/> Yes <input type="checkbox"/> No	
Growth Hormone Imbalance <input type="checkbox"/> Yes <input type="checkbox"/> No	
Acanthosis Nigricans <input type="checkbox"/> Yes <input type="checkbox"/> No	
Diabetes Type I <input type="checkbox"/> Yes <input type="checkbox"/> No	
Diabetes Type II <input type="checkbox"/> Yes <input type="checkbox"/> No	
Diabetes Insipidus <input type="checkbox"/> Yes <input type="checkbox"/> No	
Hypoglycemia <input type="checkbox"/> Yes <input type="checkbox"/> No	
Adrenal Insufficiency <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, does student require Solu-Cortef in emergencies? <input type="checkbox"/> Yes <input type="checkbox"/> No
Other:	

### Cancer

Student has none of the following conditions.

Does student currently have, or have they ever had, any form of cancer?  Yes  No

If Yes, describe type of cancer, complications, long-term effects, ongoing treatment or other important information:  
If in remission, for how long?

### Bladder, Kidney, Liver

Student has none of the following conditions.

Type of Problem	If Yes, explain. Describe complications, long-term effects, ongoing treatment or other important information.
Urination Problems (pain, burning, etc.) <input type="checkbox"/> Yes <input type="checkbox"/> No	
Bedwetting <input type="checkbox"/> Yes <input type="checkbox"/> No	
Incontinence Enuresis (involuntary urination) <input type="checkbox"/> Yes <input type="checkbox"/> No	
Require catheterization <input type="checkbox"/> Yes <input type="checkbox"/> No	
Other:	

### Nervous System, Neurological

Student has none of the following conditions.

Does the student have a ventricular shunt?  Yes  No    If yes:  Right  Left  Both Sides  
 Is/Are the shunt(s) currently functioning?  Yes  No

Type of Problem	If Yes, explain. Describe complications, long-term effects, ongoing treatment or other important information.
Seizures <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>	Date of Last Seizure: Description of Seizure: Does student have Diastat? <input type="checkbox"/> Yes <input type="checkbox"/> No
Cerebral Palsy <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>	
Muscular Dystrophy <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>	
Multiple Sclerosis <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>	
Paralysis <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>	
Traumatic Brain Injury (TBI) <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>	
Tourette's Syndrome <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>	
Other:	

If you selected "yes" to any of the above, has the student ever had a neurological exam?  Yes  No  
 If so, when:

### Skin

Student has none of the following conditions.

Type of Problem	If Yes, explain. Describe complications, long-term effects, ongoing treatment or other important information.
Eczema <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>	
Other:	

### Muscle, Bone

Student has none of the following conditions.

Type of Problem	If Yes, explain. Describe complications, long-term effects, ongoing treatment or other important information.
Joint Pain/Stiffness/Arthritis <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>	
Missing Arm, Leg, Finger, Toe <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>	
Limited Muscle Control/Tone Issues limiting: sitting, balance, or arm/leg movement <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>	
Other:	

## Orthopedic and Adaptive Equipment

Student has none of the following conditions.

Orthopedic and Adaptive Equipment	Explain below what staff needs to know related to any orthopedic or adaptive equipment student uses or needs to use.
Special Bath Equipment/Benches <input type="checkbox"/> Yes <input type="checkbox"/> No	
Support Cane/Crutches <input type="checkbox"/> Yes <input type="checkbox"/> No	
Bracing <input type="checkbox"/> Yes <input type="checkbox"/> No	
Ankle-Foot Orthotic (AFO) <input type="checkbox"/> Yes <input type="checkbox"/> No	
Walker <input type="checkbox"/> Yes <input type="checkbox"/> No	

Does student need assistance with any adaptive equipment (e.g., putting on an AFO or brace)?  Yes  No

Wheelchair  Yes  No

**If student uses a wheelchair, provide the following additional information:**

Manual  Power  or Both  Comments: \_\_\_\_\_

Any special transfer equipment or technique?  Yes  No Comments: \_\_\_\_\_

Any special concerns for bus or van travel?  Yes  No Comments: \_\_\_\_\_

Can student negotiate bus/van steps with help and travel in the vehicle seat?  Yes  No

Comments: \_\_\_\_\_

Does student require a wheelchair lift vehicle?  Yes  No Comments: \_\_\_\_\_

After entering vehicle, can student transfer to and ride in vehicle seat? Or does student need to ride in the wheelchair?  
 Vehicle Seat  Wheelchair Comments: \_\_\_\_\_

### Travel with Special Orthopedic Equipment:

**Which one statement best describes student's ability to travel using special orthopedic equipment?**

- Is totally dependent on adult to push/drive wheelchair or to steer walker, support cane or crutches
- Manages school/campus travel using equipment, but must have adult assistance within arm's reach for safety purposes
- Manages school/campus travel using equipment, but must have adult assistance within sight/hearing distance to verbally give direction
- Is able to travel safely with orthopedic equipment, staying on sidewalks, avoiding obstacles, people, and drop-offs (curbs), requiring minimal adult supervision

**Non-Food Allergies**

Student has none of the following conditions.

Type of Problem	Describe complications, long-term effects, ongoing treatment or other important information.
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**Food or Drink:** Tell us about student's food or drink allergies in the "Diet and Eating" section on page 12.

**Has student ever used or been prescribed an Epi-Pen?**  Yes  No    If yes, for what allergen? Explain:

**Environmental Allergy** (ex. mold, dust, plants, trees):  Yes  No    If yes, explain and describe below.


**Insect, Spider, Animal Allergy:**  Yes  No    If yes, explain and describe below.


**Medication Allergy:**  Yes  No    If yes, explain and describe below.


**Latex, Fragrances, Lysol or Other Allergy:**  Yes  No    If yes, explain and describe below.

**Dental**

Student has none of the following conditions.

Type of Condition	If Yes, explain. Describe complications, long-term effects, ongoing treatment or other important information.
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Problems with Teeth or Gums <input type="checkbox"/> Yes <input type="checkbox"/> No	
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Dental Retainer/Braces <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Which one?
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Other:

## Menstrual

**Student does not menstruate.**

For students who have menstrual periods:

Are they regular?

Yes: How often do they occur? (for example, every 28 days) \_\_\_\_\_

No: Describe:

Does student take any medications to control menstrual pain, to regulate hormones, for birth control, or for any other use related to menstruation?  yes  No

Does student need any assistance in order to manage her menstrual needs?  Yes  No If so, describe:

## Miscellaneous

**Student has none of the following conditions.**

Type of Problem	If Yes, explain. Describe complications, long-term effects, ongoing treatment or other important information.
Frequent Headaches <input type="checkbox"/> Yes <input type="checkbox"/> No	
Frequent Dizziness or Fainting <input type="checkbox"/> Yes <input type="checkbox"/> No	
Other:	

## Diet and Eating

### Eating and Swallowing Difficulties

**Student has no eating or swallowing difficulties.**

Does student cough, clear his/her throat, or choke when he or she swallows?  Yes  No If yes, explain:

Does student experience a running nose or tearing eyes associated with a swallow?  Yes  No If yes, explain:

Has student ever had a swallowing evaluation done by an Occupational Therapist or Speech Pathologist?

If yes, what test was performed? \_\_\_\_\_ Date of most recent test: \_\_\_\_\_

Has student ever had a Modified Barium Swallow Study (MBSS-video x-ray of the swallow)?  Yes  No

If yes, when was the study performed?

Has student ever had swallowing therapy?  Yes  No

If yes, when was the study performed (approximate date range)? \_\_\_\_\_ to \_\_\_\_\_

Special Modifications	
<input type="checkbox"/> <b>Student has no need for special modifications</b>	
Modification	If Yes, tell us what staff needs to know about any modification so that student may eat properly and safely.
Positioning <input type="checkbox"/> Yes <input type="checkbox"/> No	
Postural supports during or after eating <input type="checkbox"/> Yes <input type="checkbox"/> No	
Aspiration <input type="checkbox"/> Yes <input type="checkbox"/> No	
Choking Risk (due to over-stuffing, big bites, or eating too fast) <input type="checkbox"/> Yes <input type="checkbox"/> No	
Chewing <input type="checkbox"/> Yes <input type="checkbox"/> No	
Swallowing <input type="checkbox"/> Yes <input type="checkbox"/> No	
Adaptive Equipment and Special Eating Supplies (adapted plates, cups, bowls, spoons, forks, knives) <input type="checkbox"/> Yes <input type="checkbox"/> No	
Frequency of Eating <input type="checkbox"/> Yes <input type="checkbox"/> No	
Liquids During or Between Meals <input type="checkbox"/> Yes <input type="checkbox"/> No	
Other:	

Special Food and Drink Preparation
<input type="checkbox"/> <b>Student has no need for special food preparation—food consistency, bite size or preparation.</b>
<p>Student requires food of the following consistency:</p> <p><input type="checkbox"/> <b>SOFT &amp; BITE SIZED</b>- Soft + Bite-sized, tender and moist throughout. Chewing ability needed. Can be mashed with a fork and food does not return to original shape. Bites are no larger than the width of a fork. (IDDSI Level 6)</p> <p><input type="checkbox"/> <b>MINCED &amp; MOIST</b>- Very soft, small moist lumps, minimal chewing ability needed. Biting is not required. Particle sizes are small enough to fit through the prongs of a fork. (IDDSI Level 5)</p> <p><input type="checkbox"/> <b>PUREED</b>- Smooth with no lumps, not sticky, no chewing ability needed. Usually eaten with a spoon. Sits in a mound on a fork and does not flow through. (IDDSI Level 4)</p> <p><input type="checkbox"/> <b>LIQUIDISED</b>- Can be eaten with a spoon or drunk from a cup. Cannot be eaten with a fork because it slowly drips through. Effort needed to drink this through a wide straw. Smooth with no lumps. (IDDSI Level 3)</p> <p>Why does student need this special food size/consistency?</p> <p>Who recommended it and when?</p> <p>Do you have a prescription from a doctor for this diet? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>

**Student has no need for special liquids preparation.**

Student requires liquids thickened to the following consistency:  nectar  honey  pudding

Why does student need this special liquids consistency?

Who recommended it and when?

Do you have a prescription from a doctor for this diet?  Yes  No

### Tube Feeding\*\*

**Student does not require tube feeding**

**Information about Tube Feeding**

**Tell us what staff needs to know about tube feeding so that we can care for student properly and safely.**

Frequency; how often?

Quantity: How much food/formula?  
Number of ounces?

#### Procedure

Gravity or Pump Feed?

For how long is special positioning needed after feeding?

Water flush or bolus after tube feeding?

Is any oral intake allowed?  
Under what circumstances?

**\*\*Please note if student's g-tube comes out, tube will be reinserted to maintain patency. Student will be transported to hospital for further medical treatment.**

### Weight Issues

**Student has none of the following conditions.**

Problem with Weight Gain/Loss/Appetite  Yes  No

If Yes, explain. Include ongoing treatment or other important supportive information.

**Required Food, Drink and/or Supplement (Not Including Vitamins)**

Student has no required food, drink, or supplements.

Type of Food and/or Drink that is Required	Reason	Please Explain (Directions, Comments)
	<input type="checkbox"/> Allergy <input type="checkbox"/> Weight Control <input type="checkbox"/> Religious <input type="checkbox"/> Other:	
	<input type="checkbox"/> Allergy <input type="checkbox"/> Weight Control <input type="checkbox"/> Religious <input type="checkbox"/> Other:	
	<input type="checkbox"/> Allergy <input type="checkbox"/> Weight Control <input type="checkbox"/> Religious <input type="checkbox"/> Other:	

**Prohibited Food and Drink**

Student has no food or drink prohibitions.

Type of Food and/or Drink that is Prohibited	Reason	Please Explain (Directions, Comments)
	<input type="checkbox"/> Allergy <input type="checkbox"/> Weight Control <input type="checkbox"/> Religious <input type="checkbox"/> Other:	
	<input type="checkbox"/> Allergy <input type="checkbox"/> Weight Control <input type="checkbox"/> Religious <input type="checkbox"/> Other:	
	<input type="checkbox"/> Allergy <input type="checkbox"/> Weight Control <input type="checkbox"/> Religious <input type="checkbox"/> Other:	

**SWIMMING**

Does student need to use earplugs when swimming?  Yes  No

**Student Skills Assessment Prior to Any Swimming Activity.** Prior to participating in any swimming activity, each student will be required to take a swimming skills test given by a TSBVI Lifeguard. Student swimming activities will be provided based on the student skills as determined by the assessment.

**Student with Seizure Disorder.** Any student with any type of seizure disorder (other than in infancy only) is required to wear a life jacket during all swim activities except when the student is within immediate physical reach of a staff member whose only responsibility during the time that the student is not wearing a life jacket is to supervise the student.

An exception to this requirement can be requested in some limited situations. Parent/guardian/adult student/other person with legal authority of students in grades 6-12 or adult students who have not had a seizure within the past three years may waive the life jacket requirement by completing the "Life Jacket Waiver" form. This form requires the written approval of the student's parent/guardian/adult student/other person with legal authority and physician, stating that the student may safely participate in swimming activities in a swimming pool without wearing a life jacket (see form for more specific information). This form is available on request from the Admissions Coordinator 512-206-9182.

**We have a separate permission form related to swimming activities.**

By signing this form, I confirm that all data has been reviewed and is correct to the best of my knowledge.

\_\_\_\_\_  
Signature of Parent or Guardian or  
Student age 18 or older who is able to give informed consent or  
Other Person with Legal Authority (Power of Attorney, Voluntary Adult Caregiver, or Agent)

\_\_\_\_\_  
Printed Name of Person Signing

\_\_\_\_\_  
Date

**PLEASE COMPLETE LAST PAGE FOR MEDICAL PROVIDER AND INSURANCE INFORMATION**

**Medical Insurance.**

What type of medical insurance does student have?

- None
- Medicaid; Recipient Number: \_\_\_\_\_ Case Number: \_\_\_\_\_
- Other: Name of Insurance Company: \_\_\_\_\_  
Name of Policy Holder: \_\_\_\_\_  
Policy Number: \_\_\_\_\_

**Student Medical and Dental Providers.**

**Primary Care Doctor:** \_\_\_\_\_ Phone Number: \_\_\_\_\_  
Area of Specialty: Primary Care \_\_\_\_\_ Fax Number: \_\_\_\_\_  
Address: \_\_\_\_\_  
Last Seen: \_\_\_\_\_  
Date of Next Recommended Visit: \_\_\_\_\_

**Eye Doctor:** \_\_\_\_\_ Phone Number: \_\_\_\_\_  
Area of Specialty: Eye \_\_\_\_\_ Fax Number: \_\_\_\_\_  
Address: \_\_\_\_\_  
Last Seen: \_\_\_\_\_  
Date of Next Recommended Visit: \_\_\_\_\_

**Dentist:** \_\_\_\_\_ Phone Number: \_\_\_\_\_  
Area of Specialty: Dentistry \_\_\_\_\_ Fax Number: \_\_\_\_\_  
Address: \_\_\_\_\_  
Last Seen: \_\_\_\_\_  
Date of Next Recommended Visit: \_\_\_\_\_

**Specialty Doctor:** \_\_\_\_\_ Phone Number: \_\_\_\_\_  
Area of Specialty: \_\_\_\_\_ Fax Number: \_\_\_\_\_  
Address: \_\_\_\_\_  
Last Seen: \_\_\_\_\_  
Date of Next Recommended Visit: \_\_\_\_\_

**Specialty Doctor:** \_\_\_\_\_ Phone Number: \_\_\_\_\_  
Area of Specialty: \_\_\_\_\_ Fax Number: \_\_\_\_\_  
Address: \_\_\_\_\_  
Last Seen: \_\_\_\_\_  
Date of Next Recommended Visit: \_\_\_\_\_

## **Permission to Contact Medical/Dental Providers**

I give permission for TSBVI to contact any of the above-listed medical providers:  yes  no

## **Staff Administration of Student Medication on Fieldtrips**

I give permission for a TSBVI staff member who is not a licensed nurse or doctor to administer student's medicine on field trips according to the medical instructions provided by the prescribing physician:  yes  no

## **Medical and Health-Related Evaluation; Treatment of Minor Injuries and Illnesses**

I give permission for the above-named student to receive routine medical and health-related evaluation and treatment of minor injuries and illnesses including physician-prescribed medication and non-prescription medication.  yes  no

## **Emergency Medical and Surgical Treatment**

I give permission for student to receive emergency medical and surgical treatment determined necessary by an attending physician. I understand that the Texas School for the Blind and Visually Impaired will make every reasonable effort to contact me before any prescriptions, doctor appointments or emergency treatment is administered. In the event that further permission is needed during such treatment, please contact the following person who has the authority to make medical decisions for the student:  yes  no

## **Blood Testing**

In the event a staff member or other student is exposed to this student's blood or body fluids, I give permission for TSBVI to conduct a blood test on student for infectious diseases.  yes  no