



**Medical Form Information**

Student's legal name \_\_\_\_\_ Prefers to be called \_\_\_\_\_

Home phone: \_\_\_\_\_ Date of birth \_\_\_ / \_\_\_ / \_\_\_ Grade \_\_\_\_\_ Gender (please circle): M F

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

**Parent information:**

	Name	Legal Guardian	Cell	Work
Mother		Y/N		
Father		Y/N		
Step-parent		Y/N		

	Name	Phone
Pediatrician/primary care provider		
Dentist		

**Insurance Company:** \_\_\_\_\_

Policy number \_\_\_\_\_ Phone \_\_\_\_\_

**Emergency contact** who will assume responsibility if parent cannot be reached:

Name: \_\_\_\_\_ home \_\_\_\_\_ cell \_\_\_\_\_

Name: \_\_\_\_\_ home \_\_\_\_\_ cell \_\_\_\_\_

Date of last tetanus shot: \_\_\_\_\_

*(In case of accident or serious illness, the school will contact the parent/guardian. If the school is unable to contact the parent/guardian or person designated above, the school will make necessary arrangements for immediate treatment. Payment of any fees will be assumed by the parent/guardian.)*

**I hereby give my consent to any hospital and/or licensed physician or authorized provider to administer necessary emergency treatment to my child in the event such treatment is imperative and I cannot be contacted.**

**( ) YES ( ) NO**

Name \_\_\_\_\_

### Medical History

**Please indicate below (X) if your student has any of the following, and describe any treatments/medications, or special considerations:**

	Asthma (worsened by exercise? Y N ) (*Inhaler? Y N)
	Allergies (list all)_____ (*EpiPen? Y N)
	Cardiac Issues
	Diabetes
	Gastrointestinal Issues
	Hearing Issues
	Kidney/Bladder Issues
	Migraines
	Orthopedic Issues
	Seizures
	Vision Issues (glasses/contacts/other _____)
	Other (list: _____)

**\*If your child requires having an inhaler and/or EpiPen at school, please have your physician complete the authorization form/treatment plan; these can be found on the website or obtained from the school nurse.**

Surgical history: Type(s)\_\_\_\_\_ Year(s)\_\_\_\_\_

Disabilities or restrictions: \_\_\_\_\_

Monitoring devices or medical equipment to be used while at school? \_\_\_\_\_

Medications your student takes regularly: \_\_\_\_\_

Any other information about your child that would be helpful for the school nurse to know:  
\_\_\_\_\_

**No medications (over the counter or prescription) will be administered by the school nurse, other school personnel, or self administered by the student without the written authorization of a parent and physician/authorized provider. All prescription medications must be brought to school in the original container with the student's name and prescription information on the label.**

All over-the-counter medication dosages will be administered according to the manufacturer's recommendations on the label unless otherwise indicated by a physician. Generic substitutions may be used for non-prescription medications listed. These forms will also be the authorized form used for off campus activities, including overnight trips.

**\*\*Medication Authorization forms can be found on the website or obtained from the school nurse\*\***