

KNOX COUNTY SCHOOLS
Student Medical Profile

This information will be used by the school nurse to provide care for your child.

Date: _____

Student's Name: _____
(Last) (First) (Middle)

Grade: _____ Homeroom: _____

Did the Student require medical care/hospitalization at birth or at any other time? _____ Yes _____ No. If yes, please explain: _____

Does the student require a daily medical procedure performed by a school nurse? If so explain: _____

What medications, if any, does the student take? _____

Does the student seem to have vision, hearing or speech problems? _____ Yes _____ No. If yes, please explain: _____

The student has a history of (Check any that apply): C= Current P= Past

C P	C P	C P	C P
☐ ☐ ADD/ADHD	☐ ☐ ADD/ADHD	☐ Down's Syndrome	☐ ☐ Shunts/hydrocephalus
☐ Amputation(s)	☐ ☐ Celiac disease	☐ ☐ "G" / "J" feeding tubes	☐ ☐ Skin problems
☐ ☐ Asthma/reactive airway disease	☐ Cerebral palsy	☐ ☐ Heart defects	☐ ☐ Stomach problems
_____ Requires inhaler (Please provide school)	☐ Crohn's Disease	☐ Hemophilia	☐ ☐ Swallowing problems
☐ ☐ Allergies:	☐ Cystic fibrosis	☐ ☐ Migraine headache	☐ ☐ Tracheotomy
_____ Bee stings	☐ Diabetes	☐ Muscular dystrophy	☐ ☐ Traumatic Brain Syndrome
_____ Food: _____		☐ Spina bifida	☐ ☐ Traumatic spinal injury
_____ Latex		☐ ☐ Orthopedic problems	☐ ☐ Urinary problems
_____ Requires Epi-pen (please provide school)		☐ ☐ Sensitivity to light	☐ ☐ Other: _____
		☐ ☐ Seizure disorder	

If any are checked above, please explain: _____

It is important for teachers and principals to have your child's special medical information so that any emergency can be handled appropriately. Summarize any special medical conditions: _____

Does your child require any special dietary accommodations? _____ If you answered yes and you want your child to eat at school please obtain and have your child's doctor fill out the dietary accommodations form.

Form completed by: _____ Date: _____

Relationship to the student _____