# Ionia Public School Student Medical Information Sheet

***PLEASE RETURN THIS FORM TO THE SCHOOL SECRETARY. THE SCHOOL SECRETARY WILL GIVE THIS FORM TO THE SCHOOL NURSE.***

Student Name:_____ Birthdate:_____

School: _____ Teacher: _____ Grade____

Today's date_____

**Please check any of the following conditions that apply to your child:**

**Allergies: Bee Sting Allergy____ Allergic to Peanuts_____ Allergic to Penicillin_____**

**Is there an Epipen ordered for this allergy: Yes____ No_____**

**Asthma____ Does your child have an inhaler: Yes___ No____**

**Diabetic____ Insulin: Yes____ No____ Oral medication: Yes___ No____**

**Hemophilia (Blood disorder)____ Please explain_____**

**Seizures___ Please explain: Type_____Prescribed medication_____**

**Frequency_____ Duration_____**

Medication Allergy: Please Explain_____

Food Allergy: Please Explain_____

***Any food allergies listed will require a Doctor's order attached to this form.***

Chronic Respiratory Problems: Please Explain_____

Heart Disease: Please Explain_____

Any other conditions/Special needs: Please Explain_____

_____

Please list all current medications (even if taken at home):_____

_____

**I may need to share this information with the Staff: Is that ok? Yes___No___**

Completed by: _____

Relationship to Student:_____

Parent phone number_____