Student Medical History Form
School Year _____-_____

Student Name: _____ DOB: _____ Grade/PAA _____

Parent: _____ Relationship: _____

Phone: _____

Parent: _____ Relationship: _____

Phone: _____

Drug Allergy(s): ____ None Known ____ Yes (list): _____

____*My child has* ***No Known Medical Conditions****. (You may stop here, if there are no known medical conditions and your child does not need medicine at school.* ***Please sign at the bottom and return****.*

____ **Asthma** Triggers: ____Environmental/Seasonal ____Exercise ____Upper Respiratory Infection

____Other: _____

____Inhaler at School*(Requires Form) ____Self Carry*(Requires Form)

____**Diabetes** ____Type I ____Type II Date Diagnosed:_____ Insulin By: ____Pump ____Injections

____**Allergies** Food: ____Peanuts ____Tree Nuts ____Milk ____Others:_____

Severe Sting: ____Bees ____Wasps ____ Ants ____ Others:_____

____Epi Pen/Benadryl at school*(Requires form)

____**Seizure Disorder**(Explain):_____

____Diagnosed with a **Concussion** in the last year? Date of Diagnosis: _____

____**ADHD, ODD, Anxiety** (Explain):_____

____**Other Conditions:** _____

Does your student take any routine medication(s)? ____No ____Yes List medication(s):_____

_____

Does your child need medication(s) at school? ____No ____Yes If you marked yes, please provide the appropriate medication with completed required forms. *The medication policy and forms can be found on the FLA website or you may contact your school nurse.

The information in this form is accurate to the best of my knowledge and I give permission to the School Staff/School Nurse to share information regarding my student's medical condition(s) with pertinent school employees, my physician or emergency personnel. I also give FLA permission to call 9-1-1 and have my student transported to a hospital if emergency care is needed.

Parent/Guardian Signature: _____ Date: _____