

**COVINGTON INDEPENDENT PUBLIC SCHOOLS
HEALTH SERVICES' MEDICAL INFORMATION FORM**

In order to assure the best care for your child, please provide the following information.

Child's name: _____ Date of Birth: _____

Parent/Guardian: _____ Phone No. _____

Emergency Contact: _____ Phone No: _____

Physician Name: _____ Phone No.: _____

Does your child have any allergies? Yes No List: _____

Type of Reaction: _____

Please describe any medical conditions: _____

Please list all medications your child takes on a regular basis:

Will this child be taking any medications at school?

If yes, please list _____

Does your child's health condition require any special considerations at school?

Has your physician provided in writing that your child needs special accommodations in school? YES NO If yes, please provide a copy to school.

This information will be released to all the following school personnel on a need to know basis.

* Bus Driver(s) * Classroom Teacher(s) * Counselor * Principal * Dean/Asst. Principal
* Speech/OT/PT/ School Psychologist * Family Resource Center/ Youth Service Center

Please indicate if you do not want this information shared with school personnel.

I hereby authorize release of any needed information to and from the above named physician and emergency contacts.

I give permission for my child named above to be taken by school personnel or ambulance for treatment in the case of an accident or sudden illness when I or the emergency contact listed above cannot be reached.

Parent/Guardian Signature: _____ Date: _____