

Major Medical Conditions or Life-Threatening Allergies



THIS FORM MUST BE COMPLETED ONLY FOR A STUDENT WITH A MAJOR MEDICAL CONDITION.

School Year: _____

Student Name: _____ Birth Date: _____
Please print

School: _____ Grade: _____ Teacher/Counselor: _____

Medical Condition(s):

List or describe the student's medical condition (eg. seizures, diabetes, hemophilia etc.)

Symptoms:

Special Precautions or Treatment:

Allergies:

What is your child allergic to?

What is the reaction? (hives, lip swelling, belly pain...)

What is your child allergic to?	What is the reaction? (hives, lip swelling, belly pain...)

This form may be reviewed by medical staff.

Date: _____ Phone Number: _____ Alternate Phone Number: _____

Parent/Guardian Name: _____

Parent/Guardian Signature: _____