

STUDENT MEDICAL INFORMATION

In the event of illness or injury, I/we authorize my child to have any medical/dental attention that may be deemed necessary. I/we authorize that my child be released to the individuals listed on the Student Demographic Update Information/Emergency Card when I/we cannot be reached by phone.

Parent/Guardian Signature _____ Date _____

Insurance Provider _____
 Doctor's Name _____ Phone: _____

Medications

Is the student currently taking medication for a chronic/ongoing condition? Yes _____ No _____

List any medications: _____

Does this student need to take any medication prescribed by the physician during the regular school day? Yes _____ No _____

If you answered yes to the previous question, please have your healthcare provider fill out and sign the Authorization to Administer Medication at School form available at the school office.

Allergies

Does the student have any food allergies? Yes _____ No _____

If yes, list the foods: _____

Is an epinephrine auto-injector prescribed? (EpiPen, Twinject, Auvi-Q, Kaiser generic) Yes _____ No _____

Is the student allergic to bee stings? Yes _____ No _____ Unknown _____

If yes, describe the reaction and what medications are used: _____

Is an epinephrine auto-injector prescribed? (EpiPen, Twinject, Auvi-Q, Kaiser generic) Yes _____ No _____

Is your child allergic to any medications? Yes _____ No _____

If yes, list the medications: _____

List any other allergies the student has: _____

Asthma

Does the student have asthma diagnosed by a physician? Yes _____ No _____

Will this student have an inhaler for asthma at school? Yes _____ No _____

Seizures

Does the student have a seizure disorder? Yes _____ No _____

If yes, list type and frequency of seizures: _____

Have you completed a Seizure Action Plan? Yes _____ No _____

Diabetes

Does the student have diabetes? Yes _____ No _____

If yes, list treatment type: _____

Vision / Hearing / Mobility Needs

Does the student wear: Glasses/Contacts? Yes _____ No _____

Hearing Aid(s)? Yes _____ No _____

Does the student use: A Wheelchair? Yes _____ No _____

Other mobility devices/needs? Yes _____ No _____

If yes, list mobility devices/needs here: _____

Other

List any other current or past medical conditions/surgeries: _____

Parent/Guardian Signature _____