

# Medical Information/Release Form

\*ALL FORMS MUST BE DATED AND SIGNED\*

This medical information and release form is vital in the care of your student while at school. It provides us with information to treat your child and also includes essential information such as health concerns. If your child needed immediate emergency care, it would be extremely important for the health office to have this information available.

PLEASE REMEMBER TO PROVIDE UPDATED INFORMATION TO THE NURSE WHEN HEALTH CHANGES OCCUR.

ID#: \_\_\_\_\_ STUDENT NAME: \_\_\_\_\_ GRADE: \_\_\_\_\_ PHYSCD: \_\_\_\_\_ EMCD: \_\_\_\_\_ D.O.B: \_\_\_\_\_

IF NEITHER PARENT/GUARDIAN CAN BE CONTACTED, I AUTHORIZE THE SCHOOL ADMINISTRATION TO TAKE SUCH EMERGENCY ACTION AS NEEDED.

SIGNATURE OF PARENT/GUARDIAN \_\_\_\_\_ DATE: \_\_\_\_\_

## ALLERGIES:

Insects/Bees: \_\_\_\_\_ Severe? YES  NO  Epi-Pen Required? YES  NO  Benadryl Required? YES  NO

Foods (list): \_\_\_\_\_ Severe? YES  NO  Epi-Pen Required? YES  NO  Benadryl Required? YES  NO

Medications (list): \_\_\_\_\_ Severe? YES  NO  Explain: \_\_\_\_\_

Environmental (list): \_\_\_\_\_ Severe? YES  NO  Explain: \_\_\_\_\_

DOES YOUR CHILD NEED AN ASTHMA INHALER DURING THE SCHOOL DAY OR FOR SPORTS? YES  NO   
(If yes, please complete appropriate forms)

PLEASE MARK THE CORRECTIVE DEVICES STUDENT MAY WEAR TO SCHOOL:

GLASSES  CONTACTS  HEARING AID  ORTHOPEDIC AIDES  OTHER

ANY KNOWN HEALTH CONDITIONS: \_\_\_\_\_

CURRENT TREATMENT: \_\_\_\_\_

ANY ILLNESSES, INJURIES, OR SURGERY SINCE LAST YEAR: YES  NO

(If yes, please explain) \_\_\_\_\_

MEDICATIONS TAKEN AT SCHOOL ON A REGULAR BASIS:

Medication: \_\_\_\_\_ Dose: \_\_\_\_\_ Frequency: \_\_\_\_\_ Reason: \_\_\_\_\_

Medication: \_\_\_\_\_ Dose: \_\_\_\_\_ Frequency: \_\_\_\_\_ Reason: \_\_\_\_\_

Medication: \_\_\_\_\_ Dose: \_\_\_\_\_ Frequency: \_\_\_\_\_ Reason: \_\_\_\_\_

MEDICATION TAKEN AT HOME ON A REGULAR BASIS:

Medication: \_\_\_\_\_ Dose: \_\_\_\_\_ Frequency: \_\_\_\_\_ Reason: \_\_\_\_\_

Medication: \_\_\_\_\_ Dose: \_\_\_\_\_ Frequency: \_\_\_\_\_ Reason: \_\_\_\_\_

Medication: \_\_\_\_\_ Dose: \_\_\_\_\_ Frequency: \_\_\_\_\_ Reason: \_\_\_\_\_

DOCTOR: \_\_\_\_\_ DR PH#: \_\_\_\_\_ DENTIST: \_\_\_\_\_ DENTIST PH#: \_\_\_\_\_

Names of siblings living at home (K-8):

School now attending:

Grade:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

# FORMA DE INFORMACION MEDICA

\*ESCRIBA AL FECHA Y FIRME\*

Esta forma de informacion medica es de mucha importancia para el cuidado de su estudiante durante horarios de clases. Si su estudiante necesitara el cuidado en un caso de emergencia, seria extremadamente importante que la oficina de salud contara con esta informacion medica inmediatamente.

POR FAVOR RECUERDE PROVEER INFORMACION ACTUALIZADA A LA REGISTRADORA DE LA ESCUELA.

ID#: \_\_\_\_\_ ESTUDIANTE NOMBRE: \_\_\_\_\_ CLASE: \_\_\_\_\_ PHYSCD: \_\_\_\_\_ EMCD: \_\_\_\_\_ D.O.B: \_\_\_\_\_

EN EL DEVIDO CASO QUE NO PODAMOS COMUNICARONOS CON LOS PADRES/PERSONA CON CUSTODIA, YO AUTORIZO AL PERSONAL DE ADMINISTRACION DE LA ESCUELA QUE SE ACTUE EN CASO DE UNA EMERGENCIA CON MI ESTUDIANTE.

FIRMA PADRES/CUSTODIA: \_\_\_\_\_ FECHA: \_\_\_\_\_

## ALERGIAS:

Insectos/Abejas: \_\_\_\_\_ Severa? SI  NO  Epi-Pen Requiere? SI  NO  Benadryl Requiere? SI  NO

Comidas (por favor anote): \_\_\_\_\_ Severa? SI  NO  Epi-Pen Requiere? SI  NO  Benadryl Requiere? SI  NO

Alergia a Medicamento (por favor anote): \_\_\_\_\_ Severa? SI  NO

Medioambiental (por favor anote): \_\_\_\_\_ Severa? SI  NO

DURANTE EL AÑO, SU ESTUDIANTE NECESITA ALGUN INHALADOR PARA DEPORTES? SI  NO

(Si la respuesta es si, complete la forma de autorizacion medica.)

POR FAVOR CIRCULE CUALQUIER APARATO, MECANISMO QUE SU ESTUDIANTE NECESITARA EN LA ESCUELA:

LENTES  CONTACTOS  AUDIFONO AUXILIAR  ORTOPEDICO  OTRO

ALGUNA CONDICION DE SALUD (Especifique): \_\_\_\_\_

TRATAMIENTO ACTUAL: \_\_\_\_\_

ALGUNA ENFERMEDAD, GOLPE SERIO, O CIRUGIA DURANTE ESTE AÑO PASADO: SI  NO

(Si la respuesta es si, explique.) \_\_\_\_\_

## MEDICAMENTO DIARIAMENTE QUE TOME EN ESCUELA:

Nombre de Medicamento: \_\_\_\_\_ Dosis: \_\_\_\_\_ Frecuencia: \_\_\_\_\_ Razon: \_\_\_\_\_

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Nombre de Medicamento: \_\_\_\_\_ Dosis: \_\_\_\_\_ Frecuencia: \_\_\_\_\_ Razon: \_\_\_\_\_

## MEDICAMENTO DIARIAMENTE QUE TOME EN CASA:

Nombre de Medicamento: \_\_\_\_\_ Dosis: \_\_\_\_\_ Frecuencia: \_\_\_\_\_ Razon: \_\_\_\_\_

Nombre de Medicamento: \_\_\_\_\_ Dosis: \_\_\_\_\_ Frecuencia: \_\_\_\_\_ Razon: \_\_\_\_\_

Nombre de Medicamento: \_\_\_\_\_ Dosis: \_\_\_\_\_ Frecuencia: \_\_\_\_\_ Razon: \_\_\_\_\_

MEDICO: \_\_\_\_\_ MD PH#: \_\_\_\_\_ DENTISTA: \_\_\_\_\_ DENTISTA PH#: \_\_\_\_\_

Los nombres de los hermanos que viven en el hogar (K-8):	Ahora asisten a escuela:	Clase:
_____	_____	_____
_____	_____	_____
_____	_____	_____