Major Medical Conditions or Life-Threatening Allergies

GRAND RAPIDS CHRISTIAN SCHOOLS

THIS FORM MUST BE COMPLETED <u>ONLY</u> 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...)

This form may be reviewed by medical staff.

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

Parent/Guardian Name: _____

Parent/Guardian Signature: _____