2024-2025 Student Medical Information Sheet

STUDENT

Name _____ Grade 9 10 11 12
Last First Middle

Date of Birth_____ Sex M F Age_____

PARENTS/GUARDIANS

Name_____Home Ph_____Work _____

Address_____
Street City State Zip Code

Name_____Home Ph_____Work _____

Address_____
Street City State Zip Code

EMERGENCY Persons to be contacted in case of emergency (*will use this order until one is found*)

	Legal Age Adult	Relationship	Phone #1	Phone #2
1				
2				
3				

INSURANCE Company_____Policy Number_____

ID# _____ Group# _____

Name of Physician_____ Ph _____

Now under a physician's care? Y N Date of last tetanus shot?_____

Does the student have previous history of: *CIRCLE if Yes*

Head injuries, seizures	Hernia	Diabetes (Type_____)	Rheumatic Fever
Fainting	Neck injury	Kidney Disease and/or injury	Allergy to medication
Concussion or convulsion	High Blood Pressure	Removed or NonFunctioning —	Skin Disease
Bleeding tendencies	Bone and/or joint injury	---- Kidney/Lung/Eye	Contact Lenses/Glasses
Asthma	Tuberculosis Disease	Hepatitis	
Allergy	Sickle Cell Anemia	Surgical Operation	

Is student taking medication regularly? Y N

Please list all medications and any illness listed above requiring medication being taken at the present time_____

_____

_____

_____

May we administer a non-prescription drug, if we deem it necessary? Y N (preferred type_____

I hereby consent for medical care to be given to
_____ (student name)
in case of an emergency.

_____ _____
Prarent/Guardian Signature *Date*