

Medical Information Sheet

Sherman Independent School District ID# _____

Teacher: _____ Grade: _____ Sex ____ M ____ F Date of Birth: _____

Pupils Name: _____ Phone # _____

Address: _____

Doctor: _____ Name of Previous School _____

Location of Previous School: _____ Attended SISD Before: ____ Yes ____ No

If Yes, when? _____ Campus: _____ Grade: _____

Date of Enrollment: _____ Parents Name: _____

IMMUNIZATIONS: ATTACH XEROX COPY OF SCHOOL IMMUNIZATION RECORD

If you are coming from another Texas school immunizations will be requested from previous school but if they are not received or are incomplete, it is the parents' responsibility to provide them. We are required by law to have them within 30 days after enrollment. Texas State Immunization requirements may differ from other states. Our SISD Health Services will evaluate the immunization records received and let you know if any additional shots are needed.

MEDICAL HISTORY: Is your child subject to:	YES	NO		YES	NO
Asthma (MUST be diagnosed)			Epilepsy/Convulsions/Seizures		
Allergy: FOOD			Ear Problems		
Allergy: OTHER			Eye Problems		
Bee Sting Allergy (Severe ONLY)			Heart Disease: What? Affects how?		
Chicken Pox? If yes, when?			Hepatitis?		
Daily Medication Taken?			Tonsils/Adenoids: REMOVAL DATE:		
Diabetes?			OTHER: (Please be Specific)		

IF **YES** TO ANY ANSWERS ABOVE, PLEASE ELABORATE:

Asthma: Does student require medication at school? Yes ____ No ____ Medication Name _____

Name of Doctor: _____ Doctor Phone #: _____ Medication kept at school? ____ Yes ____ No

What is your child allergic to? _____ How does this allergy show? _____

Is emergency medication required for this allergy ____ Yes ____ No -- If yes, what _____

Describe diabetes, asthma or seizure treatment plan (Use extra pages if needed) _____

What medication does your child take on a regular basis? _____

Has your child been hospitalized for a serious illness or accident? ____ Yes ____ No --If yes, when, where and why? _____

Note: I understand that I must keep this record up to date. I will inform the school nurse of any changes in the above information. A blank space of lack of signature will not relieve me of the above responsibility.

Parent Signature: _____ Date: _____