KNOX COUNTY SCHOOLS

Student Medical Profile

This information will be used by the school nurse to provide care for your child.

Date: _____

Student's Name: _____
(Last) (First) (Middle)

Grade: _____ Homeroom: _____

Did the Student require medical care/hospitalization at birth or at any other time?_____Yes_____No. If yes, please explain: _____

Does the student require a daily medical procedure performed by a school nurse? If so explain: _____

What medications, if any, does the student take? _____

Does the student seem to have vision, hearing or speech problems?_____Yes_____No. If yes, please explain: _____

The student has a history of *(Check any that apply): C= Current P= Past*

C	P		C	P		C	P		C	P	
☐	☐	ADD/ADHD	☐	☐	ADD/ADHD	☐		Down's Syndrome	☐	☐	Shunts/hydrocephalus
☐		Amputation(s)	☐	☐	Celiac disease	☐	☐	"G" / "J" feeding tubes	☐	☐	Skin problems
☐	☐	Asthma/reactive airway disease	☐		Cerebral palsy	☐	☐	Heart defects	☐	☐	Stomach problems
			☐		Crohn's Disease	☐		Hemophilia	☐	☐	Swallowing problems
		____ Requires inhaler (Please provide school)	☐		Cystic fibrosis	☐	☐	Migraine headache	☐	☐	Tracheotomy
☐	☐	Allergies:	☐		Diabetes	☐		Muscular dystrophy	☐	☐	Traumatic Brain Syndrome
		____ Bee stings				☐		Spina bifida	☐	☐	Traumatic spinal injury
		____ Food: _____				☐	☐	Orthopedic problems	☐	☐	Urinary problems
		____ Latex				☐	☐	Sensitivity to light	☐	☐	Other: _____
		____ Requires Epi-pen (please provide school)				☐	☐	Seizure disorder			

If any are checked above, please explain: _____

It is important for teachers and principals to have your child's special medical information so that any emergency can be handled appropriately. Summarize any special medical conditions: _____

Does your child require any special dietary accommodations? _____ If you answered yes and you want your child to eat at school please obtain and have your child's doctor fill out the dietary accommodations form.

Form completed by: _____ Date: _____

Relationship to the student _____