



SANDRIDGE

ELEMENTARY SCHOOL

STUDENT MEDICAL INFORMATION FORM

SCHOOL YEAR 2026-2027

This form must be completed by the parent/guardian to assist the School Nursing Office in providing safe and appropriate care for your child while at school. Please notify the school immediately of any changes to your child's medical information.

STUDENT INFORMATION

Student Name: _____

Date of Birth: _____

Grade: _____

Parent/Guardian Name: _____

Primary Phone Number: _____

Email Address: _____

EMERGENCY CONTACT

Emergency Contact Name: _____

Relationship to Student: _____

Phone Number: _____

Authorized to Pick Up Student:

☐ Yes

☐ No

MEDICAL HISTORY

Does your child have any of the following medical conditions? (Check all that apply.)

☐ Asthma

☐ Environmental Allergies

☐ Migraines

☐ Diabetes

☐ Heart Condition

☐ Sickle Cell Disease

☐ Seizure Disorder

☐ ADHD/ADD

☐ Bleeding Disorder

☐ Food Allergies

☐ Anxiety

☐ Hearing Impairment

☐ Medication Allergies

☐ Autism Spectrum Disorder

☐ Vision Impairment

☐ Other: _____

ALLERGY INFORMATION

Does your child have any allergies?

☐ No

☐ Yes (Please complete below)

Allergy	Reaction/Symptoms

Parent/Guardian Signature: _____ Date: _____



Sandridge Elementary School

School Nursing Office

Student Health Services

School Year 2026-2027

School Nursing Office Review Date: _____

Reviewed By: _____

TOGETHER WE LEARN. **TOGETHER** WE LEAD.



SANDRIDGE

ELEMENTARY SCHOOL

School Nursing Office – Student Health Services
STUDENT MEDICAL INFORMATION FORM (BACK SIDE)

School Year 2026–2027



1. PRESCRIBED MEDICATIONS

Does your child currently take any prescribed medications?

- ☐ No
☐ Yes (List below)

Medication Name	Reason for Medication	Dosage	Taken at School?
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

Important: Any medication required during the school day must be accompanied by the appropriate medication authorization forms and supplied according to school policy.



2. HEALTH CONDITIONS, RESTRICTIONS, OR SPECIAL INSTRUCTIONS

Please provide any medical conditions, physical restrictions, accommodations, dietary concerns, behavioral health considerations, physician recommendations, or special instructions that school personnel should be aware of.



3. EDUCATIONAL ACCOMMODATIONS AND SUPPORT SERVICES

Is your child currently receiving any educational accommodations or support services?

- ☐ No
☐ Yes (Check all that apply)
☐ Individualized Education Program (IEP)
☐ Section 504 Plan
☐ Other Educational Support Plan: _____

If applicable, please provide any health-related accommodations, services, or special considerations included in the student's educational plan that the School Nursing Office should be aware of.



4. MEDICAL EQUIPMENT USED AT SCHOOL

(Check all that apply)

- | | |
|--|--|
| ☐ Inhaler | ☐ Wheelchair |
| ☐ EpiPen® / Epinephrine Auto-Injector | ☐ Crutches |
| ☐ Blood Glucose Monitor | ☐ Hearing Aid(s) |
| ☐ Insulin Supplies | ☐ Glasses |
| ☐ Seizure Rescue Medication | ☐ Orthopedic Device/Brace |
| ☐ Other: _____ | |



5. HEALTHCARE PROVIDER INFORMATION

Primary Healthcare Provider: _____

Medical Practice/Clinic: _____

Office Phone Number: _____

Preferred Hospital or Emergency Medical Facility: _____



6. PARENT/GUARDIAN ACKNOWLEDGMENT

I certify that the information provided on this Student Medical Information Form is true, accurate, and complete to the best of my knowledge.

I understand that the health and safety of my child may depend upon the accuracy of the information provided. I agree to notify Sandridge Elementary School and the School Nursing Office immediately of any changes to my child's medical conditions, medications, allergies, healthcare providers, emergency contacts, or other health-related information during the school year.

I understand that additional physician-completed forms, action plans, or medication authorization forms may be required for students with asthma, severe allergies, diabetes, seizure disorders, or other medical conditions requiring specialized health services during school hours.

I authorize the School Nursing Office to review and maintain this information as part of my child's confidential educational health record in accordance with applicable state and federal privacy laws.

Printed Name: _____

Signature: _____

Date: _____



7. SCHOOL NURSING OFFICE USE ONLY

	Yes	No
Health Care Plan Needed	☐	☐
Medication Authorization Needed	☐	☐
Emergency Action Plan Needed	☐	☐
Additional Documentation Requested	☐	☐
Follow-Up Required	☐	☐

Date Received: _____ Reviewed By: _____

Nursing Notes: _____



Sandridge Elementary School • School Nursing Office – Student Health Services

Home of the Wildcats!

