

Student ID: Homeroom #: **STUDENT MEDICAL FORM**

Thank you for entering the contact and medical information on this form. After completing your Family Homework at the Skyward Family Portal, fill out this form and send to school with your child to the attention of the school nurse. ***Please enter the same contact and emergency contact information on this form that you enter into the Skyward Family Portal for this school year.***

STUDENT INFORMATION

Last name	First Name	Date of Birth	Grade
Residence Address	City	State	Zip Code
Mailing Address (if different from Residence Address)	City	State	Zip Code

Student lives with: ☐ Both parents ☐ Parent & step-parent ☐ Mother only ☐ Father only ☐ Guardian

PARENT/GUARDIAN INFORMATION (SAME AS ENTERED IN FAMILY PORTAL)

Parent/Guardian Name	Relationship to Student	Email Address
Primary Phone Number	Secondary Phone Number	Other Phone Number
Parent/Guardian Name	Relationship to Student	Email Address
Primary Phone Number	Secondary Phone Number	Other Phone Number

ALTERNATE EMERGENCY CONTACTS (SAME AS ENTERED IN FAMILY PORTAL)

Last name	First Name	Relationship to student
Primary Phone Number	Secondary Phone Number	
Last name	First Name	Relationship to student
Primary Phone Number	Secondary Phone Number	

Complete the medical information on the opposite side of this form.

Student ID: _____

Homeroom #: _____

STUDENT MEDICAL FORM

MEDICAL INFORMATION

Physician Name _____

Phone Number _____

Is the student allergic to bee stings? YES ☐ NO ☐

If YES, explain reaction and treatment:

List any allergies the student has to medication, food, or other substances:

List any daily medications the student is taking:*

Please indicate if the student has any of the following (check box):

- | | | |
|---|--|---|
| ☐ Asthma | ☐ Glasses or Contacts | ☐ Migraine Headaches |
| ☐ Attention Deficit Disorder | ☐ Hearing Problem/Hearing Aid | ☐ Seizure Disorder |
| ☐ Diabetes | ☐ Heart Problem | |
| ☐ Psychological Problem (depression, anxiety, social or behavioral difficulties) | | |

Other chronic illnesses/conditions that require special attention:

I permit sharing confidential medical information listed above with select school personnel:

☐ YES ☐ NO

Indicate type of medical insurance: ☐ Private ☐ CHIP ☐ Medical Assistance ☐ None

Other: _____

I give my permission for this student to receive the following medication (MUST check YES or NO for every medication):

Tylenol

(Acetaminophen)

☐ YES ☐ NO

Advil

(Ibuprofen)

☐ YES ☐ NO

Benadryl

(Diphenhydramine)

☐ YES ☐ NO

TUMS

(antacid – Calcium Carbonate)

☐ YES ☐ NO

Signature of Parent or Guardian: _____

Date: _____

** A doctor's order and parent permission is required to dispense any additional medications to students. Students are NOT permitted to carry any medication on them in school (except for EpiPens, Inhaler, or Insulin with appropriate medical documentation on file). All medication must be safely stored in the nurse's office and dispensed by the nurse. If your child is required to take any medication during school hours it must be provided in a labeled pharmacy bottle or in original container. A parent or responsible adult must transport all controlled medications to school. Contact your school nurse regarding medication administration and to complete the appropriate form.*