

NAME _____

2024-2025 Student Medical Information Sheet

Period _____

STUDENT

Name _____
Last First Middle

Grade 9 10 11 12

7 8

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.

Parent/Guardian Signature _____

Date _____