



MEDICAL INFORMATION FORM 2011-2012

Student's Name _____ DOB _____ Sex _____

ParentsName _____ Home phone # (1) _____ ph#(2) _____

	<p>Parent or Guardian must complete this page, sign the back of this form, and return the form to the school.** Please mark the check box next to any condition or illness that applies to your child. Note: for medication questions, please mark the "yes" box only if child is taking medication <u>now</u>.</p>
1.	<input type="checkbox"/> Allergies to: <input type="checkbox"/> Food: _____ <input type="checkbox"/> Medicine: _____, <input type="checkbox"/> Ants, <input type="checkbox"/> Wasps, <input type="checkbox"/> Bee stings, <input type="checkbox"/> Environmental or other. Please list: _____ Specify reaction to allergy or allergen: <input type="checkbox"/> Rash, <input type="checkbox"/> Swelling, <input type="checkbox"/> Hives, <input type="checkbox"/> Trouble Breathing, <input type="checkbox"/> Vomiting, <input type="checkbox"/> Diarrhea, <input type="checkbox"/> Other _____ <input type="checkbox"/> Takes medication for any allergies. Name medication(s): _____ Does child need a special diet? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, the school will require a Diet Modification Form from a doctor. Obtain the Diet Modification Form on-line or from the School Nutrition Manager.)
2.	<input type="checkbox"/> Asthma. Diagnosed at age: _____ Under doctor's care now? <input type="checkbox"/> Yes <input type="checkbox"/> No List triggers: _____ <input type="checkbox"/> Takes medication for asthma. Name medication(s): _____
3.	<input type="checkbox"/> Attention Deficit/Hyperactivity Disorder (ADD/ADHD). <input type="checkbox"/> Takes medication. Name medication(s): _____
4.	<input type="checkbox"/> Blood disorder <input type="checkbox"/> Sickle cell anemia <input type="checkbox"/> Bleeding condition. Specify: _____
5.	<input type="checkbox"/> Cancer. Explain: _____
6.	<input type="checkbox"/> Cystic Fibrosis <input type="checkbox"/> Takes medication. Name medication(s): _____
7.	<input type="checkbox"/> Diabetes. Does child require insulin? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Takes medication. Name medication(s): _____
8.	<input type="checkbox"/> Digestive disorders. Explain: _____
9.	<input type="checkbox"/> Head injury (serious). Explain: _____
10.	<input type="checkbox"/> Hearing problem <input type="checkbox"/> Uses hearing aid.
11.	<input type="checkbox"/> Heart condition. Explain: _____ Under doctor's care for this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No; Any physical restrictions? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain: _____
12.	<input type="checkbox"/> High Blood Pressure (Hypertension) <input type="checkbox"/> Takes medication. Name medication(s) _____
13.	<input type="checkbox"/> Hypoglycemia (low blood sugar). <input type="checkbox"/> Takes medication. Name medication(s) _____
14.	<input type="checkbox"/> Kidney or bladder disorder. Explain: _____
15.	<input type="checkbox"/> Mental Health Condition. <input type="checkbox"/> Takes medication. Name medication(s) _____
16.	<input type="checkbox"/> Migraines. Under doctor's care for migraines? <input type="checkbox"/> Yes <input type="checkbox"/> No; <input type="checkbox"/> Takes medication. Name medication(s) _____
17.	<input type="checkbox"/> Muscle/bone/mobility disorder. Explain: _____
18.	<input type="checkbox"/> Respiratory condition (other than asthma). Explain: _____ Name medication(s) _____
19.	<input type="checkbox"/> Seizure Disorder. Type of seizure(s): _____ How long ago was the last one? _____ <input type="checkbox"/> Takes medication. Name medication(s) _____
20.	<input type="checkbox"/> Surgery? Explain: _____ Date _____
21.	<input type="checkbox"/> Vision problems. Explain: _____ <input type="checkbox"/> Glasses <input type="checkbox"/> Contacts
22.	<input type="checkbox"/> Other medical condition not listed. Explain: _____
23.	<input type="checkbox"/> My child does <u>not</u> have any of the listed conditions or illnesses.

Please explain any medical condition that may affect your child's school performance or program participation:

****Please complete and sign the back page****

Does student have Medicaid? Yes No Doctor's name: _____ Ph. #: _____

Medical Insurance Yes No

Insurance Provider _____ Medical Insurance ID# _____

****Please provide the information below for the responsible adults to contact if parents can't be reached****

Name	Home phone	Work phone	Relationship
1.			
2.			
3.			
4.			

PARENTAL CONSENT

School: _____

Grade: _____

Student's Full Name: _____

Date of Birth: _____

I hereby give consent for my child to participate in the School Health Services Program. This program includes emergency care, health appraisal at school and monitoring for communicable diseases. It also includes the following state mandated health screenings: vision screening in grades Preschool, K, 1, 3, 6; hearing screening in grades Preschool, K, 1, 6; growth and development screenings in grades Preschool, 1, 3, 6; and scoliosis screening in grade 6. Additional screenings, other than the state mandated, may be done upon request.

I am aware that in order for my child to receive any medication or medical treatment at school, I must provide a new Authorization for Medication/Treatment signed by myself and my child's doctor each school year. All medications must be brought to school by an adult. All medications and/or treatment, equipment or supplies must be supplied by the parent/guardian.

In case of serious accident or illness, I request the school to contact me. If the school is unable to reach me, I hereby authorize the school to contact one of the adults listed on the Emergency and Contact Information Form whom I have designated to notify in an emergency. In the event the emergency contacts cannot be reached, the school may make whatever arrangements are necessary to provide care and treatment for my child. **When necessary, and in the event that I, or any of the emergency contacts cannot be reached, school personnel have my permission to request transport of my child to the nearest emergency room.** Under such circumstances, school personnel have my permission to release the information on this form to emergency personnel. I understand and agree that I will be responsible for any emergency medical services fees.

In case of accident or illness where, in the best judgment of school personnel, emergency treatment of my child is not needed, but where he/she is unable to remain at school, I request the school to contact me to pick up my child. If the school is unable to contact me, I understand that one of the adults listed on the Emergency and Contact Information Form whom I have designated to notify in an emergency and who are also designated to pick up my child will be contacted.

I understand and agree that certain educational records of my child may be shared with the School Board's health care partners as needed to provide and evaluate health services to students. I also understand and agree that my child's medical treatment records created by health care personnel at school may be shared with school officials who have a legitimate educational purpose for accessing such treatment records. I understand and agree that it is my responsibility to notify the school of any changes in the information recorded on this form.

I certify that the information I have provided on this Medical Information Form is accurate, true and correct.

Date: _____

Parent/Guardian Signature: _____

Print Parent/Guardian Name: _____