

MEDICAL INFORMATION

Last Name: _____ First Name: _____ M.I. _____

Date of Birth _____ Age _____ Gender: M/F Grade: _____ Room _____

Does your child have any:

ALLERGIES? _____ No _____ Yes (if yes please answer below)

What type? _____

Allergy treatment? _____

ASTHMA? _____ No _____ Yes (if yes please answer below)

How treated? _____

MEDICATIONS? _____ No _____ Yes (if yes please answer below)

Please list all medications your child is currently taking.

1. _____ dosage _____ 2. _____ dosage _____

To be given at school? _____ No _____ Yes

Other Medical Conditions? _____ No _____ Yes (if yes please answer below)

What type? _____

How treated? _____

Does your child wear glasses? _____ No _____ Yes (if yes please answer below)

For what condition? _____

Any special dietary needs? _____ No _____ Yes (if yes please explain below)

Child's Doctor's Name: _____ Doctor's Phone# _____

Date of most recent physical: _____

Health Insurance Provider Covering Student: _____

Policy number: _____ Group Number _____

Child's Dentist's Name: _____ Dentist's Phone # _____

Date of most recent dental exam: _____

Parent/Guardian Signature: _____

DATE RECEIVED
(to be stamped by office)

