

MEDICAL INFORMATION

STUDENT NAME _____

Grade _____

Campus _____

PLEASE CHECK ANY OF THE CATEGORIES THAT PERTAIN TO YOUR STUDENT.

Medical Conditions:

Asthma _____
Seizure Disorder _____
Blood Disorders _____
Heart Problems _____
Congenital Problems _____
Diabetes _____
High Blood Pressure _____
Rheumatic Fever _____
Muscular Disorder _____
Speech Disorder _____
Urinary Disorder _____
Joint Pain _____
Other _____

Behavioral Problems:

Tires Easily _____
Under/Over Weight _____
Nail Biting _____
Nervousness/Restlessness _____
Shyness _____
Over-Aggressive _____
Frequent Stomachaches _____
Bed-Wetting _____
Disturbed Sleep _____
Other: _____

Nose, Mouth, Throat

Frequent Colds _____
Nosebleeds _____
Frequent Sore Throat _____
Sinusitis _____
Dental Problems _____
Other _____

Eyes:

Vision Loss _____
Wears Glasses/Contacts _____
Squinting _____
Frequent Headaches _____
Eyes Water _____
Lazy Eye _____
Other: _____

Ears:

Earaches _____
Drainage _____
Hearing Loss _____
Deafness _____
Tubes _____
Other: _____

Allergies:

Medications _____
Other: _____

Surgery:

Major: _____
Minor: _____

SCHOOL POLICY REQUIRES A WRITTEN DOCTOR'S ORDER FOR ALL MEDICATIONS THAT WILL BE GIVEN FOR LONGER THAN A FOUR WEEK PERIOD. CONTACT THE SCHOOL NURSE IF YOUR STUDENT NEEDS ASSISTANCE WITH A MEDICAL PROCEDURE OR CONDITION.

ANY UNMARKED BOX WILL BE CONSIDERED A "NO"

In the event that I can not be reached by any mechanism, and my child has a temperature above 102, the school health services may provide age appropriate dose of Acetaminophen

_____ YES _____ NO

Parent/Guardian Signature

Date