

Student Name: _____ School: _____

Teacher Name: _____ Entering Grade: _____

School Year: _____

MEDICAL INFORMATION

Doctor/Physician: _____ Phone Number: _____ Address: _____

Dentist: _____ Phone Number: _____ Address: _____

Preferred Hospital: _____

LIFE-THREATENING ALLERGIES/SERIOUS MEDICAL CONDITION(S)

Your child cannot start his/her first day of school until a medical alert conference is held.

This meeting will be scheduled as soon as possible, and no later than three (3) school days after the day of registration.

YES NO

My child has a life-threatening allergy.

Please specify: _____

My child has a serious medical condition.

Please specify: _____

Name of Parent/Guardian Signature Today's Date (Month/Day/Year)

MEDICAL HISTORY: *In order for us to assist your child in gaining the most from his/her school experience, it is necessary to have a current health history.*

HAS YOUR CHILD EVER HAD, OR DOES HE/SHE NOW HAVE:	YES	NO	DESCRIPTION
Allergies			
Food			
Medication			
Bee sting			
Other			
Injuries – Concussion – Head Injury			
Frequent or Excessive Nose Bleeds			
Hospitalizations - Operations			
Orthopedic – Bone or Joint Problems			
Asthma			
Diabetes			
Sickle Cell Anemia			
Anemia			
Hearing Loss – Use of Hearing Aids			
Vision Loss – Wears Contacts/Glasses			
Speech Condition			
Dizziness, Fainting, Severe or Frequent Headaches			
Seizures/Convulsions/Epilepsy			
Heart Conditions			
Contact with Tuberculosis/A Positive Tuberculin Skin Test			
Severe Abdominal Pain – Ulcer			
Excessive Ear Infections			
Excessive Colds			
Frequent or Painful Urination			
Intestinal Condition			
Family History of Scoliosis			
Excessive Worry, Anxiety, or Depression			
PLEASE LIST ANY MEDICATION(S) YOUR CHILD TAKES REGULARLY:			

ANY OTHER INFORMATION THAT MIGHT BE HELPFUL FOR US TO KNOW ABOUT YOUR CHILD, OR CIRCUMSTANCES AT HOME, THAT COULD AFFECT HIM/HER AT

SCHOOL? _____

Parent: _____ Date: _____