Student's Name:_____ Date of Birth:_____ Grade:_____

Physician's Name:_____ Phone Number:_____

Please circle any that apply to your student and explain below.

Allergies:
Bees/Insects
Latex
Food
Medication
Seasonal/Environmental
***Epi Pen? (with nurse/with student)**

Behavioral/Psychological:
ADD/ADHD
Anxiety or Depression
Autism
Conduct Disorder
PTSD
Other:

Vision:
Wears Glasses
Wears Contacts
Blindness
Color Blindness
Other:

Bowel/Digestive:
Irritable Bowel Syndrome
Crohn's Disease
Bowel Incontinence

Cardiovascular:
High Blood Pressure
Heart Murmur
*Any Restrictions?

Endocrine:
Type 1 Diabetes
Type 2 Diabetes
Other:

Hearing:
Hearing Impairment
Wears Hearing Aids

Musculoskeletal:
History of Fractures
Other:

Neurological:
Migraine
Headaches
History of Concussion
Seizure Disorder

Respiratory:
Asthma/Reactive Airway
***Inhaler? (with nurse/with student)**

Urinary:
Urinary Incontinence
History of Urinary Infections

Blood:
Anemia
Hemophilia
Sickle Cell Anemia

Explain any circled concerns:_____
_____
_____

Medications(list ALL medications taken- at home and/or at school): _____
_____

The school will act based on information provided here. It is expected that this form is accurate, complete and any changes will be reported as soon as possible. I give permission for this information to be shared with school staff on a need to know basis. The information provided will be treated as confidential and protected. I understand that in the event of reasonable attempts to contact myself or my child's emergency contacts have been unsuccessful, I give my consent for emergency medical treatment deemed necessary. I understand that I am financially responsible for any medical care or transportation costs. I release and agree to hold the Board of Trustees, its officials and it's employees harmless from all liability for damages or injuries. I also consent to the release of any additional medical information to the school nursing staff.

Parent/Guardian's Signature: _____ Date:_____