STUDENT MEDICAL DATA FORM

Please complete a separate Medical Form for each child including infants/toddlers

20__ - 20__ Family ____________________________

Student's Full Name ____ Age ________ Date of Birth _______________

Nickname (if commonly used) ____ Birth Gender__________________

Does this child have any allergies? YES NO Does this child carry/use an epi-pen? YES NO

List allergies & reactions to each: ____

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Does this child have asthma? YES NO Does this child carry/use an inhaler? YES NO

Is the asthma exercise induced only? YES NO

Inhaler Medication Name/Dose: ____

Does this child have any significant medical conditions (i.e. diabetes, epilepsy, joint or ligament disorders, etc.) or have they had any surgeries, hospitalizations, or significant injuries in the last 3 years: YES NO

If Yes, explain condition & dates if applicable: ____

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Does this child regularly take any medications (including over the counter medications)? YES NO

Is this child currently prescribed any medication. YES NO

List name of medication, dose, prescribing physician & reason for taking the medication. If a child regularly takes an over the counter medication, please list medication, dose, and reason for use: ____

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Please submit a copy of the child's most current immunization records no later than Back to School Night.

OFFICE USE ONLY: Student Immunizations Received Date _______________