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: _____