STUDENT MEDICAL INFORMATION

Student Name: _____

PLEASE PRINT

Address: _____ Zip: _____

Phone: _____ Birth Date: _____ Social Security #: _____

OPTIONAL

Parent/Guardian Name: _____

Address: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____

Other Emergency contact(s): _____ Phone: _____

Address: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____

Doctor: _____ Phone: _____

Address: _____ Zip: _____

Hospital Preference: _____ Phone: _____

Insurance coverage: Yes ____ No ____

Name of Insurance Company: _____

DOES THIS STUDENT HAVE ANY MEDICAL ISSUES? Yes ____* No ____

* If yes, please explain _____

_____

_____

_____

Is this student taking any medications? (*Medication includes nonprescription drugs: i.e. aspirin, etc*.)

Yes ____ No ____ Name of medication and potential side effects:_____

_____

Do these medications need to be administered at school?

Yes ____ No ____ (*If yes please specify and request and fill out the Student Medication Administration form)*

**If necessary, attach a letter to the school from his/her doctor containing instructions for medications and medical protocol.*

Does the student self administer his medication? (*If so please request a Student Self-Medication Administration Form*)

Is this student allergic to any drugs? Yes ____ No ____

(*If yes, please specify)* _____

Is this student allergic to insect bites or stings? Yes ____ No ____

(*If yes, please specify)*_____

If yes, does this student have an insect bite kit for emergencies? Yes ____ No ____

What date did this student receive his/her last tetanus shot? _____

<u>It is the responsibility of the Parent/Guardian to notify the student's school of any change of information contained on this form during the course of the school year</u>.