

MEDICAL INFORMATION SHEET

STUDENT NAME: _____ **DOB:** _____ **GRADE:** _____

ALLERGIES

Bee Stings: NO YES Describe reaction: _____

If yes, describe treatment: _____

Food Allergies: NO YES Name of food: _____

If yes, describe reaction: _____

Describe treatment: _____

Other Allergies and treatment needed: _____

ASTHMA

NO YES If yes, please fill out an Asthma Action Plan

ATTENTION DEFICIT DISORDER/ATTENTION DEFICIT HYPERACTIVITY DISORDER

(ADD/ADHD) NO YES

If yes, does your child take medication NO YES If yes, please list medication, time taken and dosage _____

Would you like your child to take his/her medication at school NO YES If yes, please see the nurse.

DIABETES

NO YES If yes, please see the nurse.

SEIZURES

NO YES

If yes history of seizures/not currently on medications takes medication at home

may need emergency medications at school (see nurse)

HEARING OR VISION CONCERNS:

OTHER MEDICAL ISSUES:

OTHER MEDICATIONS: HOME SCHOOL Please list _____

PHYSICAL RESTRICTIONS:

Uses mobility aid (wheelchair, walker, crutches, etc.)

Must avoid the following activities: _____

(Doctor's note may be required for Physical Education adaptations)

IN AN EMERGENCY I AUTHORIZE MEDICAL/DENTAL CARE:

HOSPITAL PREFERENCE: BILLINGS CLINIC ST VINCENT EITHER

CHILD'S DOCTOR: _____ PHONE # _____

CHILD'S DENTIST: _____ PHONE # _____

PARENT'S SIGNATURE: _____ DATE: _____

This health information may be shared with school personnel as necessary to benefit the health and safety of your student and others. Please keep this information up to date