This information will be used by the school nurse to provide care for your child.

Student's name _____
(LAST) (FIRST) (MIDDLE)

Did the student require medical care/hospitalization at birth or at any other time?

☐ Yes ☐ No If "Yes," explain: _____

_____

Does the student require a daily medical procedure performed by a school nurse? If so, explain:

_____

What medications, if any, does the student take? _____

_____

Does the student seem to have vision, hearing or speech problems?

☐ Yes ☐ No If "Yes," explain: _____

The student has a history of (check any that apply):

- ☐ ADD/ADHD
- ☐ Amputation(s)
- ☐ Asthma/reactive airway disease
  - ☐ Requires inhaler
- ☐ Allergies:
  - ☐ Bee stings
  - ☐ Food _____
  - ☐ Latex
  - ☐ Requires Epi-pen
- ☐ Cancer
- ☐ Celiac disease
- ☐ Cerebral palsy
- ☐ Crohn's Disease
- ☐ Cystic fibrosis
- ☐ Diabetes
- ☐ Down's Syndrome
- ☐ "G"/"J" feeding tubes
- ☐ Heart defects
- ☐ Hemophilia
- ☐ Migraine headache
- ☐ Muscular dystrophy
- ☐ Spina bifida
- ☐ Orthopedic problems
- ☐ Sensitivity to light
- ☐ Seizure disorder
- ☐ Shunts/hydrocephalus
- ☐ Skin problems
- ☐ Stomach problems
- ☐ Swallowing problems
- ☐ Tracheotomy
- ☐ Traumatic Brain Syndrome
- ☐ Traumatic spinal injury
- ☐ Urinary problems
- ☐ Other _____

If any are checked, explain: _____

_____

It is important for teachers and principals to have your child's special medical information so that any emergency can be handled appropriately. Summarize any special medical conditions:

_____

_____

_____

_____

_____

Does the student get along well with other people?

☐ Yes ☐ No If "No," explain: _____

Family physician: _____ Telephone: _____

Form completed by _____ **Date** _____

Relationship to the student _____