STUDENT NAME: _____DOB:_____ GRADE: _____

HOSPITAL PREFERENCE: _____ DOCTOR: _____ PHONE: _____

CURRENT MD DIAGNOSED MEDICAL CONDITIONS:

(Please see the school nurse to discuss your child's medical condition and to complete a health care plan.)

PLEASE CHECK ALL THAT APPLY:

_____ASTHMA requires inhaler __yes __no

_____DIABETES Type 1_____ Type 2_____

_____FOOD ALLERGY/ SEVERE! _____ _____ Epipen: __yes __no
food reaction

_____INSECT ALLERGY/ SEVERE! _____ _____ Epipen: __yes __no
insect reaction

_____ LATEX ALLERGY/ SEVERE!_____ Epipen: __yes __no
reaction

_____SEIZURE DISORDER takes daily medication at home _____ at school _____

_____MEDICATION ALLERGY_____ _____
medication reaction

_____OTHER _____

DAILY MEDICATION TAKEN AT HOME: _____

DAILY MEDICATION TAKEN AT SCHOOL: (any prescription medication given at school requires a physician's written statement and parental consent form.)

_____

_____

ACTIVITY RESTRICTIONS: (REQUIRES A NOTE FROM THE PHYSICIAN/PARENT TO THE PE TEACHER):

_____

_____

****REMEMBER-STOCK EPIPENS DO NOT GO ON FIELDTRIPS…ALSO…. STOCK EPIPENS ARE NOT FOR USE OUTSIDE OF SCHOOL HOURS-IF STUDENT REQUIRES HIS/HER OWN EPIPEN-PARENT MUST PROVIDE****

_____ ******STUDENT HAS NO MD DIAGNOSED HEALTH PROBLEMS******

_____ ____ _____
Parent Signature Date