STUDENT MEDICAL HEALTH DATA FORM – EFFECTIVE FROM_____TO_____

School _____Student Name_____ Date of Birth_____

Legal Guardian (1) _____Relationship to Student _____

Phone: Home _____ Bus: _____ Cell_____

Legal Guardian (2) _____Relationship to Student _____

Phone: Home _____ Bus: _____ Cell_____

Name of Emergency Contact_____ Relationship to Student_____

Phone: Home _____ Bus: _____ Cell: _____

Is the emergency contact authorized to collect the student from school? Yes ☐ No ☐

Medical/Health Data

☐ Student has **NO** medical or physical condition, which may impede full and safe participation in school programs or extra-curricular activities.

Form completed by: _____

Legal Guardian (please print) *Signature*

_____ _____ _____

Student Name (please print) Signature Date

☐ The Student has medical or physical condition(s) which may require attention during school programs or extra-curricular activities, **The school/legal guardian will prepare a medical emergency plan.**

Is the condition life-threatening? Yes ☐ No ☐

Medical/Physical Condition and Health Factors: (*please identify symptoms, conditions or warning signs that indicate that treatment or assistance is required)*

Allergies/anaphylaxis: List any life threatening allergic reactions. (e.g., peanuts, bee stings, etc.)

Medications/procedures to follow.

Frequency: Treatment/Assistance is usually required: regular/daily ☐ occasionally, "as need arises" ☐

Does student reliably: ☐request treatment / assistance when needed? ☐ take own medication when needed?

Or is **close supervision** required to ensure:
☐ need for treatment / assistance? ☐ student is taking medication properly (e.g., manner and amount prescribed?)

List any additional emergency procedures this condition may require.

ADMINISTRATION OF MEDICATION

Identify any school or extra-curricular activities that the condition makes inappropriate for the student.

_____

Does the student require regular medication for this condition? ☐ yes ☐ no

If yes, please complete the request for the administration of medication by school personnel section below.

Name/Type of Medication _____

Directions for Storage/Safe Keeping _____

Dosage/Amount to be Given _____

Method of Administration _____

Duration of Administration _____

From _____ To _____ Frequency/Times to be administered _____

Anticipated Reaction to Medication (e.g., symptoms, side effect _____

_____
Reaction to Missed Medication

_____

Will student reliably ask for medication if required? _____

Approvals

_____ _____ _____
Physician's Name *(please print)* Physician's Signature Date

_____ _____
Physician's Address *(please print)* Physician's Telephone Number

Student and/or Legal Guardian Authorization

I hereby request and give permission for medication to be administered as specified above. This medication, if administered, is administered on a voluntary basis**. This request shall expire at the time specified above or at the end of the school year or when the person transfers to another school.** This request may be cancelled upon receipt of written notification by the principal of the school in which the student is enrolled.

I give consent for school staff to use the information provided in this form to be used to attend to the health and safety of myself/my child.

I understand it is my responsibility to make a new request of the receiving principal if my child transfers to another school.

Form completed by:

_____ _____
Parent/Legal Guardian (please print) *Signature*

_____ _____
Student Name (please print) Signature