Allergy/Medication Form
Must be completed by ALL students & returned to school

STUDENT INFORMATION

Student Name _____ **Date of Birth** _____ **Grade** _____

Parent/Guardian Name _____

Physician _____ Phone # _____

HEALTH CONDITIONS: Please check all that apply to your child.

- ☐ ADD/ADHD
- ☐ Allergies (Life Threatening)
- ☐ Allergies
- ☐ Asthma/Reactive Airway
- ☐ Does child have Asthma Action Plan
- ☐ Behavioral/Emotional/ Psychological
- ☐ Blood Disorder
- ☐ Bowel Difficulty
- ☐ Brain / CNS Disorder
- ☐ Cancer
- ☐ Cardiovascular (Heart/Blood Disease)
- ☐ Cerebral Palsy
- ☐ Cystic Fibrosis
- ☐ Developmental Delay
- ☐ Diabetes
- ☐ Eating Disorder
- ☐ Endocrine Disease
- ☐ Genetic Disorder
- ☐ Head Injury/Concussion
- ☐ Hearing Disorder
- ☐ Low Blood Sugar
- ☐ Migraine Headaches
- ☐ Musculoskeletal Disorder
- ☐ Pneumonia
- ☐ Prosthesis
- ☐ Seizure Disorder
- ☐ Skin Disease
- ☐ Spina Bifida
- ☐ Urinary / Kidney Disease
- ☐ Visually Impaired
- ☐ Wear Glasses / Contacts
- ☐ Other (please explain)

Please fully explain any answers checked above (include severity and symptoms of any allergies, to include medications). Also, please list any hospitalizations/surgeries.

_____

_____

_____

MEDICATIONS: Please list any medications your child takes on a regular basis.

_____

_____

_____

ALLERGIES: Is your child allergic to any medication? If yes, please list the medication name and reaction. Is your child allergic to anything else? Please list.

Medication Allergy: _____

Food Allergy: _____

Other Allergies: _____

Please list any other health factors that the school nurse or your child's teacher(s) should know which might affect the student's school experience: _____

_____

Unless you provide the School Nurse with a valid waver, in the event of an emergency, if you cannot be reached, and we believe it necessary for the physical well being of the student, we will consult with the physician listed above, or if that physician cannot be contacted, another Medical Doctor chosen by the School Nurse or Administrator, and we will also transport the student by ambulance if deemed necessary by the Doctor or School Personnel.

_____ _____

Parent/ Legal Guardian *Date*