MEDICAL INFORMATION

Name of Student _____ Date of Birth _____

School Name _____Teacher _____School Year _____

Please ✓ check those which apply:

☐ Allergies

- ☐ Bee sting (severe reaction)
- ☐ Food (severe reaction)

  _____
- ☐ Medication (any drug reaction)

  _____
- ☐ Other (specify)

  _____

☐ Asthma

☐ Cardiac

☐ Diabetes

☐ Hemophiliac

☐ Hearing Impaired

☐ Seizure Disorder

☐ Vision Impaired

☐ Orthopedic (specify)

_____

☐ Physically handicapped (specify)

_____

Chicken Pox (Varicella) History

☐ My student had the Chicken Pox Disease at _____ years of age.

☐ My student had the Varicella Vaccine on_____ _____
Date Date

☐ **My child has no medical problems that you need to be concerned with.**

Medical Critical Needs

A student identified as having a medical critical need is one with a consistent, complex health problem that requires monitoring and may need acute life-saving intervention (diabetes, seizures, heart conditions, severe allergies, asthma, etc.).

☐ Yes, my child's condition meets the Medical Critical Needs criteria.
A *Student Care Plan* will be put into writing.

I give permission to share, if necessary, the above information with those who may be involved with the welfare of my child: school nurse, psychologist, teacher, social worker, counselor, secretary, classroom and playground aides, bus driver, and other persons involved in the emergency care of my child such as E-Unit, ambulance or hospital personnel.

Parent/Guardian signature _____ Date_____