# 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)
________________________________________

☐ **My child has no medical problems of school concern.**

**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________________

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