Rockford Public Schools
Quality Community – Quality Schools
*Together Building a Tradition of Excellence*

# MEDICAL INFORMATION

Name of Student _____ Date of Birth _____

School Name _____Teacher _____School Year _____

Primary Care Physician _____ Phone _____

Specialist Physician _____ Type _____Phone _____
(For example: Endocrinologist)

Please ✓ check those which apply:

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

Allergies: ☐ No known allergies ☐ Epinephrine Rx

- ☐ Bee Sting
- ☐ Food

_____

- ☐ Medication

_____

- ☐ Other (specify)

_____

- ☐ Diabetes
- ☐ Cardiac
- ☐ Asthma---☐ Inhaler at school
- ☐ Bleeding Disorder
- ☐ Seizure Disorder
- ☐ Physically Handicapped (specify)

_____

- ☐ Medical Toileting Needs (specify)

_____

☐ Other Medical Condition(s)/Concern(s) (specify)

_____

**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.
I will contact the school or nurse and an ***Individualized Healthcare Plan*** may 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_____