ANNUAL MEDICAL FORM

SCHOOL YEAR _____

Student Date of Birth Grade Address ☐ Unaccompanied youth	Parent/Guardian Phone Parent/Guardian Phone Emergency Phone
Physician Phone Last visit	Dentist Phone Last visit

Life Threatening Allergies:

Emergency medication	Last event

Indicate if your child has any of the following:

☐ Epilepsy or seizures Seizure Interview Form	☐ Diabetes Diabetes Interview Form
☐ Asthma or lung condition Asthma Interview Form	☐ Cardiovascular condition
☐ Sickle cell ☐ Hemophilia ☐ Other blood disorder	☐ Surgery/hospitalization/trauma history
☐ Mental health condition	☐ Other

Please list all medications that your child takes at home.

Medication	Strength, Dose, Route	Time of Day

If your child needs medication during the school day, complete this form:

Medication Authorization Form

If you need assistance with any of the following, the school nurses can provide resources to assist your family

☐ Obtaining health insurance ☐ Finding a medical, dental, or mental health provider	☐ Housing ☐ Clothing ☐ Food

By signing below, I permit the school nurse to share information about my student's health with appropriate school and medical personnel for my student's ongoing safety at school.

Parent/Gaurdian_____Date_____

May 2024