

Student Health Survey/Medical Consent Form

Directions: Please completely fill out the following form for each of your children and return to the school.

Student's Name

Grade

Address

☐ *new*

Home Phone

☐ *new*

Parent/Guardian Name

Work Phone

☐ *new*

Name & Phone Number of person(s) to be contacted in an emergency other than parent/guardian:

Name and Number of Family Doctor: _____

Does your child have any of the following health care concerns?

☐ Diabetes

☐ Acute Allergies

☐ Epilepsy

☐ Asthma

☐ Attention Deficit Disorder

☐ Other (Please Specify)

☐ Attention Deficit Hyperactivity

Please list any special medical conditions, treatments, allergies, etc. of your son/daughter:

In case of a medical emergency, I give my permission to any authorized Licensed Medical Facility or Licensed Medical Doctor to treat my son/daughter: (Student's Name) _____

(Signature of Parent/Guardian)

(Date)

Is your child currently taking a prescription medication that might need to be administered during the school day?

☐ No

☐ Yes

If yes, Please stop at the office and fill out a permission for medication form.

To the best of my knowledge, my child has none of the above medical needs.

(Signature of Parent/Guardian)

(Date)