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	Home Phone
______________________	______________________
Parent/Guardian Name	Work Phone

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

____

Name and Number of Family Doctor:________________________________

<u>Does your child have any of the following health care concerns?</u>

___Diabetes
___Epilepsy
___Attention Deficit Disorder
___Attention Deficit Hyperactivity

___Acute Allergies
___Asthma
___Other (Please Specify)

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 fill out an return the permission for medication form that was enclosed with this survey.

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

______________________ ______________________

(Signature of Parent/Guardian) (Date)