



MEDICAL INFORMATION

STUDENT: _____	CLASS: _____ MWF _____ T/TH
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***WE ALSO NEED A DAYCARE MEDICAL FORM OF YOUR CHILD'S MOST RECENT PHYSICAL**

Does this students have any known allergies (food, insects, pets, medications, seasonal, environmental?)	<input type="checkbox"/> yes <input type="checkbox"/> no	List allergy and reaction: _____ _____ _____
Does it require emergency treatment or emergency medication?	<input type="checkbox"/> yes <input type="checkbox"/> no	List Medication: 1. _____ 2. _____
If yes will there be emergency medication provided for the school?	<input type="checkbox"/> yes <input type="checkbox"/> no	List Directions to administer: _____ _____ _____

MEDICAL/SPECIAL NEEDS/ALERTS:

Has the student ever had or currently have any health problems or medical conditions?

If so please describe: _____

Is there any mental, emotional, or physical condition the school should know about? Y N

If so please describe: _____

Does your child receive any special services such as speech or occupational therapy, or have any learning difficulties? Y N

If so please describe: _____

Parent/Guardian signature: _____ Date: _____