

Perrydale School District #21

Student Medical Information

Student Name _____ Grade _____

Student's Physical Address _____

Sex: M or F Birth Date _____ Preferred Hospital _____

Doctor(s) Name _____ Phone _____

My child ☐ does/ ☐ does not have health insurance, vision insurance, dental insurance.

Insurance Company _____ Policy # _____ Group # _____

Does your child have any allergies to: Food____, Medication____, Bees____, Pollen____, Dust____, Other____

Please list any specific allergies _____

My child takes prescription medication at **home**. **Y** **N** please name medication taken _____

My child takes prescription medication at **school** **Y** **N** please name medication taken _____

My child wears: ☐ eye glasses ☐ contact lenses ☐ hearing aids ☐ other

Check any condition/disease which has the potential to present a life threatening emergency or any condition which has in the past presented a life threatening emergency.

<input type="checkbox"/> Requires epi-pen at school	<input type="checkbox"/> Emotional/Behavioral problems	<input type="checkbox"/> Hemophilia
<input type="checkbox"/> Severe bee/insect sting reaction	<input type="checkbox"/> Inhaler/Nebulizer at school	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Severe food allergy	<input type="checkbox"/> Gastrostomy	<input type="checkbox"/> Asthma
<input type="checkbox"/> Heart condition	<input type="checkbox"/> Requires catheterization	<input type="checkbox"/> Dialysis
<input type="checkbox"/> Colostomy/Ileostomy	<input type="checkbox"/> Seizure disorder	<input type="checkbox"/> Cancer
<input type="checkbox"/> Physical disability/impairment	<input type="checkbox"/> Tracheotomy	

If any of the above are checked, the student may need to have a medical protocol in place prior to entering school.

Check any of the following that your child has now or has had in the past.

<input type="checkbox"/> Migraines	<input type="checkbox"/> Skin Disorders	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Neck Injuries	<input type="checkbox"/> Gastritis	<input type="checkbox"/> Operations
<input type="checkbox"/> Back Injuries	<input type="checkbox"/> Bowel/toileting problems	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Muscle, Joints or Bone disease	<input type="checkbox"/> Urinary Tract disorder	

Please explain any checked health concerns/ or list any additional health concerns you may have about you child _____

Is there any reason your child should not be able to participate in regular school activities including sports, physical education, field trips, and other activities? Yes ____ No ____

If so, please explain _____

I hereby give my permission for my child to receive emergency medical treatment, and information on this document may be available to school and health personnel especially in the event of an emergency

Parent Signature _____

Date _____