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.

__Requires epi-pen at school
__Severe bee/insect sting reaction
__Severe food allergy
__Heart condition
__Colostomy/Ileostomy
__Physical disability/impairment
__Emotional/Behavioral problems
__Inhaler/Nebulizer at school
__Gastrostomy
__Requires catheritization
__Seizure disorder
__Tracheotomy
__Hemophilia
__Diabetes
__ Asthma
__Dialysis
__Cancer

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.

__Migraines
__Neck Injuries
__Back Injuries
__Muscle, Joints
or Bone disease
__Skin Disorders
__Gastritis
__Bowel/toileting problems
__Urinary Tract disorder
__ Arthritis
__Operations
__Ulcers

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

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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____________________________

Phone Number _________________________