MEDICAL CONDITIONS

2021-2022 SCHOOL YEAR

STUDENT NAME _____

Please check if your child has a history of any of the following medical conditions.

___ALLERGIES –mild or severe (circle one). Allergic to _____

All severe allergies require an emergency action plan form. Ask nurse for form.

Does he/she have an epipen? ☐yes ☐no Does he/she require Benadryl to be administered upon exposure? ☐yes ☐no

___ADD or ADHD- Does the student take any medication? ___yes ___no

Will the student be taking medication during school hours? ___yes ___no

If yes, a permission for med form should be filled out by a doctor. Ask for form.

___ASTHMA–Will this student require an inhaler at school? ___ yes ___no

If yes, a permission for med form should be filled out by a doctor. Ask for form.

___CEREBRAL PALSY ___HEART CONDITION ____MIGRAINES

___HEARING AID ___EPILEPSY OR SEIZURES ____KIDNEY DISEASE

___LOW BLOOD SUGAR ___LACTOSE INTOLERANCE ____DIABETES

___OTHER (Please explain) _____

_____

☐I would like for this information to be shared with any and all staff that will come in contact with my son/daughter throughout the school year. I understand that this information is only for staff awareness to help maintain the student's health and safety.

☐I do not wish this information to be shared.

PARENT SIGNATURE_____DATE_____