

MEDICAL INFORMATION FORM
Academic Year 2017-2018

Student Information:

Student _____ Birthdate _____ Grade _____
Emergency Contact _____ Phone _____
Physician _____ Phone _____
Dentist _____ Phone _____
Health Insurance Carrier _____
Health Insurance ID# _____

Medications:

Please list all medications taken at home and school, including OTC (over-the-counter) medications, i.e. seasonal allergy medication, that are used on a regular basis.

Medication	Dose	Time (s)

Please list medications that will be needed on day field trips or during sporting events off campus.

Allergies:

Does your child have any allergies? (Please circle): **YES** **NO**

If **YES**, please describe and attach physician's treatment plan.

Medical Conditions:

Please list all medical conditions or health issues.
