



# Student and Medical Information Form

\* filled out by parents \*

Student \_\_\_\_\_ Date of Birth \_\_\_\_\_

Date of Entry \_\_\_\_\_ Grade \_\_\_\_\_ Age \_\_\_\_\_ M or F \_\_\_\_\_

Parents \_\_\_\_\_

Address \_\_\_\_\_

Parent Email address \_\_\_\_\_

Cell phone #1 \_\_\_\_\_ Cell phone #2 \_\_\_\_\_

Previous School \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

## Family History

Lives with both parents \_\_\_ Shared custody\_\_\_ Single Parent\_\_\_

List any custody issues or visitation limitations that we need to know with proper documentation \_\_\_\_\_

## Medical History

Please check if Medical Diagnosis applies to your child:

**FOOD ALLERGIES** \_\_\_\_\_

EpiPen or Auvi-Q \_\_\_\_\_

Drug Allergies \_\_\_\_\_

Operations \_\_\_\_\_

Asthma \_\_\_\_\_

Injuries \_\_\_\_\_

Uses Inhaler \_\_\_\_\_

Seizures \_\_\_\_\_

Vision – glasses/contacts \_\_\_\_\_

Heart Disease \_\_\_\_\_

Hearing Difficulty \_\_\_\_\_

Other \_\_\_\_\_

In accordance with Privacy Act please sign below:

Health Information will be shared with School Personnel on a "Need to know" basis.

\_\_\_\_\_  
Signature of Parent

\_\_\_\_\_  
Date