

General Medical Profile (Complete for Health Staff and Health Folder)

Student Name: _____ **Birthdate:** / / **Grade:** _____

Doctor/Phone: _____ **Dentist/Phone:** _____

Primary Caregiver: _____ **Phone #s** _____

Medical Conditions: _____

History of Surgery/Severe Injury/Concussion: _____

Check if your student has any of the following?
*If your student has any of the conditions with **an asterisk***, ask office staff for that condition form.*

<input type="checkbox"/> Allergies – food: _____	<input type="checkbox"/> Check if Life Threatening *	<input type="checkbox"/> ADD/ADHD
<input type="checkbox"/> Allergies – insects: _____	<input type="checkbox"/> Check if Life Threatening *	<input type="checkbox"/> Frequent Ear Infections
<input type="checkbox"/> Allergies – seasonal: _____	<input type="checkbox"/> Check if Life Threatening *	<input type="checkbox"/> Fainting
<input type="checkbox"/> Allergies – misc: _____	<input type="checkbox"/> Check if Life Threatening *	<input type="checkbox"/> Vision Condition
<input type="checkbox"/> Anaphylaxis – Last episode: _____	<input type="checkbox"/> Check if Epi Prescribed	<input type="checkbox"/> Wears glasses
<input type="checkbox"/> Asthma*	<input type="checkbox"/> Check if Life Threatening	<input type="checkbox"/> Wears contacts
<input type="checkbox"/> Diabetes*	<input type="checkbox"/> Check if Life Threatening	<input type="checkbox"/> Hearing Condition
<input type="checkbox"/> Heart Problem*	<input type="checkbox"/> Check if Life Threatening	<input type="checkbox"/> Hearing Aids/devices
<input type="checkbox"/> Seizure Disorder*	<input type="checkbox"/> Check if Life Threatening	
<input type="checkbox"/> Other: _____	<input type="checkbox"/> Check if Life Threatening *	
<input type="checkbox"/> Physical Condition	<input type="checkbox"/> Therapy/Interventions _____	<input type="checkbox"/> Has Insurance
<input type="checkbox"/> Behavioral Condition	<input type="checkbox"/> Therapy/Interventions _____	
<input type="checkbox"/> Speech Condition	<input type="checkbox"/> Speech Therapy/Interventions _____	

Current Medication/s	Dose/s	Time/s Taken	For

Student Needs at school:

My student requires Medication at school (daily/as needed/emergency): _____
 A separate Medication Authorization Form is required for each medication to be given at school and for changes in dosage or time of administration.

My student requires Medical/Nursing Assistance at school: _____

My student has Physician-Ordered Food Restrictions: _____

My student has Physician-Ordered Activity Restrictions: _____

There is not a licensed nurse in the building at all times. Please direct any medical correspondence, changes of school medical orders or prescriptions for your student to the nurse at your student's school. Please keep emergency contacts updated with the school office. Parent/guardian must bring any medication your student requires at school in the original, labeled container (with Rx – for prescription medication). The information on this form will be kept in your student's health file and will be shared with school staff as needed in the interest of your student's well being, safety and education.

Parent Signature: _____ **Date:** _____