

WHAT TREATMENT, IF ANY, WILL BE NEEDED DURING SCHOOL HOURS? _____

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7. DOES THIS STUDENT HAVE ANY CARDIAC PROBLEMS? _____ YES _____ NO IF YES, PLEASE EXPLAIN FURTHER: _____
STATE RESTRICTIONS ON ACTIVITIES DUE TO CONDITION, IF ANY: _____

8. LIST AND GIVE DATES OF ANY PAST OPERATIONS: _____

9. LIST AND GIVE DATES OF ANY PAST INJURIES: _____

10. LIST AND GIVE DATES OF ANY PAST SERIOUS ILLNESSES: _____

11. IS THIS STUDENT CURRENTLY RECEIVING MEDICAL CARE FOR ANY CONDITION OTHER THAN THOSE MENTIONED ABOVE? IF SO, PLEASE EXPLAIN: _____

12. ARE THERE ANY ACTIVITIES IN WHICH THIS STUDENT CANNOT PARTICIPATE DUE TO PHYSICAL/ HEALTH REASONS? _____ YES _____ NO IF YES, PLEASE EXPLAIN: _____

13. IS THIS STUDENT ON ANY SPECIAL DIET OR RESTRICTED FROM ANY FOODS: _____ YES _____ NO
IF YES, PLEASE EXPLAIN: _____

14. IS THIS STUDENT CURRENTLY ON ANY MEDICATION? _____ YES _____ NO IF YES, PLEASE LIST ALL MEDICATION INCLUDING NAME, DOSAGE AND TIME GIVEN: _____

**PLEASE NOTE THAT IF MEDICATION WILL BE NEEDED DURING SCHOOL HOURS, PERMISSION IN WRITING MUST BE GIVEN TO THE SCHOOL NURSE FROM THE PARENT AND THE PRESCRIBING PHYSICIAN.

PHYSICIAN _____ PHONE _____

DENTIST _____ PHONE _____

HOSPITAL CHOICE _____

INSURANCE CO. _____

DATE OF FIRST POLIO VACCINE (TOPV, IPV) _____

In a medical emergency, we hereby authorize the school district to seek emergency medical assistance for our child if we cannot be reached.

THANK YOU FOR YOUR HELP IN PROVIDING THIS INFORMATION.

PARENT SIGNATURE: _____

DATE: _____