

ST CLAIR COUNTY SCHOOLS

MEDICAL FORM

Name of Student (First, Middle, Last) _____

Grade: _____ Homeroom Teacher: _____

Date of Birth _____ Age _____ Social Security # _____

Address _____

Home Phone # _____

EMERGENCY CONTACTS

List any person(s), including parents/guardians, that may take your child in case of a medical emergency. Your child will not be released to any person not listed. Proper identification must be provided to pick up student from school.

<u>Name/Relation to Student</u>	<u>Home Phone</u>	<u>Work Phone</u>	<u>Cellular Phone</u>
<u>(mom)</u> _____	_____	_____	_____
<u>(dad)</u> _____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

HEALTH INFORMATION – Check all that apply to student

Allergies:

Medicine Bees Ants Foods/Other

Health Problems:

Asthma Diabetic Heart Problems Epilepsy/Seizures
 Eye Problems Ear Problems Nose Bleeds Bleeding disorders
 Blood Diseases Operations & broken bones Other

Any other medical conditions? Yes No

Any restrictions limiting physical activity? Yes No

If you checked any of the boxes above, please describe in detail any of these conditions: _____

If your child has any conditions that limit his/her activity, a note from your doctor will be required to be excused from PE.

List any medication(s) your child takes on a regular basis: _____

In order for your child to take any medication at school, a state required form must be completed before any medications can be administered. The medication must be delivered by the parent in the original container. If it is a prescription, ask your pharmacist for a second bottle for the school. If the medicine is over the counter, the medicine must be in the original container with the student's name, dosage, and time the medication is to be dispensed.

*****ALL MEDICATION MUST BE DELIVERED TO THE SCHOOL BY AN ADULT PARENT/GUARDIAN.*****

PLEASE COMPLETE BACK PAGE OF THIS FORM.