



## Student Medical Information

\_\_\_\_\_

Child's Name

\_\_\_\_\_

Age

\_\_\_\_\_

Date of Birth

\_\_\_\_\_

Grade

Please describe any potentially *life-threatening* allergies or medical conditions: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please describe treatment and any other pertinent information:

\_\_\_\_\_

\_\_\_\_\_

Please describe any non-life-threatening conditions, special needs, or preferences which may affect your child's experience in school and any treatment or action which may be necessary or advisable:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please list your child's special dietary needs including any food allergies, intolerances, and restrictions:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Child's doctor: \_\_\_\_\_

Phone number: \_\_\_\_\_

\_\_\_\_\_

Parent Signature

\_\_\_\_\_

Date