City of Fountains school

Student Medical Information

Child's Name	Age	Date of Birth	Grade
_____	_____	_____	_____

Please describe any potentially *life-threatening* allergies or medical conditions (please attach a medical action plan to this form): _____

_____

_____

_____

_____

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

City of Fountains School allows participation in its activities, services, events and programs by persons of any race, color, national or ethnic origin, religion, sexual orientation or gender. It does not discriminate on the basis of race, color, national or ethnic origin, religion, sexual orientation or gender.