

Student Name (Last, First):		Teacher:
Medical Information		
Doctor's Name:	Doctor's Tel #:	Hospital Preference:
<p>I understand that in the event the parent/guardian cannot be reached, the school has my permission to take appropriate emergency action including calling 911. I understand it is also my responsibility to update the school as needed regarding any medical information which may impact my child during the school day.</p> <p style="text-align: right;">_____</p> <p style="text-align: right;">Signature of Parent / Legal Guardian</p>		
List any MEDICATIONS taken routinely and reason taken		
Medications	Reason Taken	
Emergency Medications:		
CURRENT MEDICAL CONDITIONS that the school staff should be aware of (such as asthma, seizure disorder, diabetes, bleeding disorder, heart or stomach problems, etc)		
Does your student need a HEALTH PLAN sent home for you to complete in order for this condition to be managed at school?		
<input type="checkbox"/> No <input type="checkbox"/> Yes _____ INITIALS		
List the ALLERGIES that your student has (such as food, insects, environmental, etc.):		
Does your student need an allergy emergency plan for school?		
<input type="checkbox"/> No <input type="checkbox"/> Yes _____ INITIALS		

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