

STUDENT Medical Information

NAME OF STUDENT: _____ D.O.B.: _____ YR.: _____

IN CASE OF EMERGENCY – HOME PH NO.: _____

MOTHER'S WORK NO.: _____ FATHER'S WORK NO.: _____

IF UNAVAILABLE, EMERGENCY CONTACT NAME: _____

HOME PHONE: _____ WORK PHONE: _____

PROBLEMS			DETAILS
HEART PROBLEMS		YES/NO	
RESPIRATORY eg ASTHMA		YES/NO	
ALLERGIES	Food	YES/NO	
	Drug	YES/NO	
	Ointments	YES/NO	
	Other	YES/NO	
DIABETES		YES/NO	
BLOOD PRESSURE		YES/NO	
RECENT OPERATIONS		YES/NO	
EPILEPSY		YES/NO	
RECENT ILLNESS		YES/NO	
PHOBIAS		YES/NO	
BACK, BONE, JOINT PROBLEMS		YES/NO	
OTHERS (including allergies)		YES/NO	

DATE OF LAST TETANUS BOOSTER: _____

MEDICATION CURRENTLY BEING TAKEN: Please give details of any medication being taken by the student including dosage, frequency and any doctor's instructions.

Please give full details of any problems – medical or physical – which would limit your student's full participation in any activity, including any food restrictions.

MEDICAL INSURANCE DETAILS OF MEDICARE CARDHOLDER'S:

NAME: _____ MEDICARE NUMBER: _____

ADDITIONAL HEALTH INSURANCE: YES/NO

Date: _____ Parent/Caregiver Signature: _____