

# Medical Information for Students

Name of student \_\_\_\_\_

Grade and homeroom teacher \_\_\_\_\_

Name and number for nurse to contact if needed

\_\_\_\_\_

Chronic illness or health problems:

Medications taken at home every day:

Medications needed at school:

Any health concerns you have:

Allergies to any food, medicines, insects or environment( please tell me reaction and treatment, if any, for each allergy):

Has your child ever been stung by a bee? YES NO

Parent signature \_\_\_\_\_ Date \_\_\_\_\_

Parent Email (optional) \_\_\_\_\_