General Medical Profile *(Complete for Health Staff and Health Folder)*

Student Name: **Birthdate**: / / **Grade**:

Doctor/Phone: **Dentist/Phone**:

Primary Caregiver: **Phone #s**

Medical Conditions:

History of Surgery/Severe Injury/Concussion:

Check if your student has any of the following?

*If your student has any of the conditions with **an asterisk***, ask office staff for that condition form.*

- ❑ Allergies – food: ____ ❑ Check if Life Threatening *
- ❑ Allergies – insects: ____ ❑ Check if Life Threatening *
- ❑ Allergies – seasonal: ____ ❑ Check if Life Threatening *
- ❑ Allergies – misc: ____ ❑ Check if Life Threatening *
- ❑ Anaphylaxis – Last episode: ____ ❑ Check if Epi Prescribed
- ❑ Asthma* ____ ❑ Check if Life Threatening
- ❑ Diabetes* ____ ❑ Check if Life Threatening
- ❑ Heart Problem* ____ ❑ Check if Life Threatening
- ❑ Seizure Disorder* ____ ❑ Check if Life Threatening
- ❑ Other: ____ ❑ Check if Life Threatening *

- ❑ ADD/ADHD
- ❑ Frequent Ear Infections
- ❑ Fainting
- ❑ Vision Condition
- ❑ Wears glasses
- ❑ Wears contacts
- ❑ Hearing Condition
- ❑ Hearing Aids/devices

- ❑ Physical Condition ❑ Therapy/Interventions ____
- ❑ Behavioral Condition ❑ Therapy/Interventions ____
- ❑ Speech Condition ❑ Speech Therapy/Interventions ____

❑ **Has Insurance**

Current Medication/s	Dose/s	Time/s Taken	For

Student Needs at school:

- ❑ My student requires Medication at school (daily/as needed/emergency): ____
  A separate Medication Authorization Form is required for each medication to be given at school and for changes in dosage or time of administration.
- ❑ My student requires Medical/Nursing Assistance at school: ____
- ❑ My student has Physician-Ordered Food Restrictions: ____
- ❑ My student has Physician-Ordered Activity Restrictions: ____

There is not a licensed nurse in the building at all times. Please direct any medical correspondence, changes of school medical orders or prescriptions for your student to the nurse at your student's school. Please keep emergency contacts updated with the school office. Parent/guardian must bring any medication your student requires at school in the original, labeled container (with Rx – for prescription medication). The information on this form will be kept in your student's health file and will be shared with school staff as needed in the interest of your student's well being, safety and education.

Parent Signature: ____ **Date**: ____