

Sample Medical Form

NAME OF STUDENT _____

DATE OF BIRTH _____

NAME OF PARENT/GUARDIAN _____

HOME PHONE _____

WORK PHONE _____

IN CASE OF EMERGENCY CONTACT PARENTS

FAMILY DOCTOR _____

/OR _____ PHONE _____

OFFICE PHONE _____

Medical Insurance Plan No.: _____

A. Please note any health problem, physical handicap, emotional difficulty, behavioural problem, or facts which may limit full participation in the science classroom.

B. Student's immunization shots are current , i.e. tetanus and diptheria, typhoid, smallpox, and polio vaccine

YES () NO ()

C. Student is subject to:

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> asthma | <input type="checkbox"/> sensitive skin | <input type="checkbox"/> sleepwalking | <input type="checkbox"/> nosebleed |
| <input type="checkbox"/> ear ache | <input type="checkbox"/> sinus trouble | <input type="checkbox"/> convulsions | <input type="checkbox"/> high blood pressure |
| <input type="checkbox"/> fainting | <input type="checkbox"/> frequent colds | <input type="checkbox"/> headache | <input type="checkbox"/> motion sickness |
| <input type="checkbox"/> tonsillitis | <input type="checkbox"/> nightmares | <input type="checkbox"/> bed wetting | <input type="checkbox"/> allergies (describe) |
| <input type="checkbox"/> eye infection | <input type="checkbox"/> bronchitis | <input type="checkbox"/> kidney problem | |

D. Student wears contact lenses ()

E. **Medications:** I would like my child to be given,

Name of Medication(s) _____

Purpose of Medication _____

In case of emergency, I hereby give permission to the physician selected by the school to provide necessary treatment for my child.

Parent/Guardian signature: _____ Date: _____