

**OHIO COUNTY SCHOOLS
Student Medical Information Form**

Student's Name _____ Grade _____ Age _____

Student's SS# _____ Birthdate _____ Sex _____

Home Address _____
(Street)

_____ (City) _____ (State) _____ (Zip Code)

Parent/Guardian Name _____ Home Phone: _____
Work Phone _____

Parent/Guardian Name _____ Home Phone _____
Work Phone _____

Alternate Adults to contact in case of emergency:

_____ Phone _____
_____ Phone _____

Physician's name _____ Phone _____
Dentist's name _____ Phone _____

CURRENT HEALTH CONDITIONS AS DIAGNOSED BY A PHYSICIAN:
(Check if apply to above-named student)

- | | | |
|---|---|---|
| <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Prosthesis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hyperactive | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Bleeding Problems | <input type="checkbox"/> ADHD/ADD | <input type="checkbox"/> Tourette's |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Intestinal | <input type="checkbox"/> Urinary Tract |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Problems | <input type="checkbox"/> Problems |
| <input type="checkbox"/> Cystic Fibrosis | <input type="checkbox"/> Muscular Dystrophy | <input type="checkbox"/> Other (specify): |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Orthopedic | _____ |
| <input type="checkbox"/> Emotional Problems | <input type="checkbox"/> Problems | |

Indicate guidelines to follow for the health problem(s) checked above _____

OHIO COUNTY SCHOOLS Student Medical Information Form (continued)

ALLERGIES: Medications _____
*Insect Sting _____
Food _____
Seasonal _____

*Insect Sting: Does your child have a SEVERE reaction with breathing difficulties requiring an IMMEDIATE INJECTION OF MEDICATION? ____yes ____no
(If 'yes', an Administration of Medication form must be filled out and signed by the doctor.)

Describe any other health problems NOT listed: _____

List any activity restrictions: _____

List daily medications (long term): _____

Student will need to take medication at school: Yes ____ No ____

(HIGH SCHOOL ONLY):

I do approve of the school nurse or designated medication provider to give my child the below dose appropriate over the counter medications:

Tylenol: ____yes ____no Antacid: ____yes ____no

Parent/Guardian Signature Date

Hospital Preference: _____

Parent/Guardian Signature Date



**PLEASE RETURN THIS FORM TO THE SCHOOL NURSE AS SOON AS POSSIBLE.
THANK YOU FOR YOUR COOPERATION.**