**MEDICAL INFORMATION FORM**

*This form will be given to the school nurse. All information is confidential.*

Student Name: Click here to enter text. DOB: Click here to enter text.

Student ID #: Click here to enter text. Grade: Click here to enter text.School:Click here to enter text.

Address:Click here to enter text.

Parent/Guardian Name: Click here to enter text.

Home Phone: Click here to enter text.Cell Phone: Click here to enter text. Work Phone: Click here to enter text.

Medical Conditions: Click here to enter text.

Life Threatening Food Allergies: Click here to enter text.

Dietary Restrictions/Food Intolerances: Click here to enter text.

Life Threatening Insect Allergies: Click here to enter text.

Mild/Moderate Insect Allergies: Click here to enter text.

Other Allergies: Click here to enter text.

Medication Allergies: Click here to enter text.

Medication(s)

At home: Click here to enter text.

At school: Click here to enter text.

Parent Signature Date

**THE ASSISTANCE WITH MEDICATION FORM IS REQUIRED TO BE COMPLETED FOR MEDICATION TO BE ADMINISTERED AT SCHOOL. STUDENTS MAY NOT TRANSPORT MEDICATION TO OR FROM SCHOOL.**