

STUDENT MEDICAL INFORMATION AND CONSENT

STUDENT

_____ Last First Middle
 MY CHILD HAS NO KNOWN HEALTH PROBLEMS MY CHILD HAS A POTENTIALLY LIFE THREATENING HEALTH CONDITION

MEDICAL/HEALTH INFORMATION

Medication: Does your child require medication at school or at home? No Yes

- If your child requires medication at school, all medication sent to school must be in the original prescription container with a current date and the child's name. An "Authorization for Administration of Medication" form must be on file.

Medication	Prescribing Physician	Dosage	Hours(s) Given

Vision and/or Hearing Problems:

Wears glasses/contacts Wears Hearing aids Other (describe): _____

Medical Conditions: Please check the appropriate boxes if your child has any of the following:

Severe Allergies

Bees/insects Food Environmental Medications
 Other Explain: _____

Please Explain Reaction: _____

*Medications Needed → Epi-Pen Benedryl Other _____

Current Asthma → Uses Inhaler On daily Medication No Medication required

Current Seizures → If checked, On Medication? Yes No

Diabetes → If Checked, Insulin Dependent? Yes No

Migraines → If checked, On Medication? Yes No

Heart Condition: Please Explain _____

Attention Deficit Disorder → On Medication? Yes No

Emotional/Psychological Disorder: Please Explain _____ Meds? Yes No

Swallowing, Stomach or Intestinal Disorder: Please Explain _____

Other, Please Explain: _____

Recent Illness, hospitalization, or surgery. If checked, please provide date(s) and description: _____

Physician/Health Care Provider:

Phone No. (____)-____-____

Dentist _____

Phone No. (____)-____-____

Health Insurance Information:

Health Plan/Group Name: _____

Policy No. _____

No Health Insurance

EMERGENCY TREATMENT AUTHORIZATION

I/we, the undersigned parent(s) or legal guardian of _____, a minor, do hereby give authorization and consent to the school to obtain emergency medical care and necessary transportation, including x-ray examination, anesthetic, medical or surgical diagnosis and emergency hospital which is deemed advisable by and is to be rendered under the general or specific supervision of medical and emergency room staff licensed under the provisions of the medicine practice act and the State of Wisconsin Department of Public Health.

It is understood that effort shall be made to contact the undersigned prior to rendering treatment to the student, but that any of the above treatment will not be withheld if the undersigned or authorized adults cannot be reached.

_____ is the hospital I/we prefer for emergency medical treatment of my/our child.

Parent/Guardian Signature

_____/_____/_____
Date