Medical Information Sheet

Student's Name_____Birthdate_____Grade_____

Parent/Guardian:_____Home Phone_____Work_____Cell_____

Physician_____Date of Last Exam_____

Dentist_____Date of Last Exam_____

Hospital Preference (in case of an emergency)_____
(If the school is unable to get a hold of you, your child will be sent to the above facility if it is medically necessary)

Immunizations: By law, all school age children are required to be up-to-date. Please call 878-7244 if you have any questions or concerns regarding your child's immunizations.

Please list all current Health Diagnosis/Conditions for the above child (Physical &/or Mental Health):
i.e. Asthma, Diabetes, ADHD_____
_____

Allergies:
The school nurse must be notified of any allergy your child may have to food(s), medication(s), seasonal, or other, and your child's reaction to the allergen, especially if an anaphylactic reaction occurs. Furthermore, the school nurse will be contacting you regarding your child's allergy for further discussion on your child's care while at school.

Please list all allergies along with the reaction (i.e. Peanuts – results in hives)
Food(s):_____
_____
Medication(s):_____
_____
Seasonal:_____
_____

Please list all current medications for the above child (drug name, time taken, and dosage):_____
_____
_____

Prescription Medications:

Every effort should be made to administer medication outside of school hours. However, the Fond du lac Ojibwe School does acknowledge that this is not always the case and will accommodate as needed for your child's medication needs.

If a prescription medication needs to be given while at school, the school nurse (or delegated personnel) has my permission to administer the prescribed medication(s) as ordered by my child's physician, and I give permission for the school nurse to contact my child's physician regarding the prescription medication.

Also, a separate form will need to be filled out for **any** prescription medication, which will include the prescribing physician's and parental signatures. This form will be given upon notification of your child's need of prescription medication administration during school hours.

X_____ _____
Signature of Parent/Guardian Date