FAYETTE COUNTY SCHOOL CORPORATION
HEALTH SERVICES MEDICAL INFORMATION FORM

Student's Name _____ Date of Birth _____

Address _____ Home Phone # _____

School_____ Grade_____ Age_____ Family Doctor _____

_____

Parent/Guardian Name Employer Work Phone Cell Phone

_____

Parent/Guardian Name Employer Work Phone Cell Phone

In case of accident/illness, contact (other than parent/guardian):

1. _____ Phone_____
(Name) (Relationship)
2. _____ Phone _____
(Name) (Relationship)

Health History (Please check all that apply.)

_____ ADHD
_____ Allergies
____Food:_____
____Insect:_____
____Medication:_____
____Seasonal:_____
____Epi-pen prescribed
_____ Ambulatory Problems
_____ Asthma
____ Inhaler
____ No Inhaler

_____ Bowel Problems
_____ Cancer
_____ Cerebral Palsy
_____ Cystic Fibrosis
_____ Diabetes
_____ Hearing Loss
_____ Heart Condition
_____ Hemophilia
_____ Immunity Problems
_____ Musculoskeletal Problems

_____ Nosebleeds
_____Seizure Disorder
_____ Spina Bifida
_____ Urinary Problems
_____Vision Problems
___ Glasses
___ Contacts
_____ Other: _____
_____ Other: _____

The following medications are available at school. Do NOT send medication with your student. Please indicate if the school has permission to administer:

	YES	NO
Antihistamine (Benadryl)		
Acetaminophen (Tylenol)		
Antacids (Tums)		

	YES	NO
Cough Drops		
Ibuprofen (Motrin/Advil)		
Cough Syrup (Robitussin)		

I understand that the above medical information I have provided may be released in the case of an emergency and/or to employees of the Fayette County School Corporation who have direct contact with my child.

_____ _____
Signature of Parent/Guardian **Date**

Related Documents: 5.37-B Parental Medication Authorization Form
5.37-C Medication Procedure
5.37-D Medication & Bus Riders
5.37-E Self Carry/Administration

Revised 7/25/00, 4/13/06, 7/1/11, 7/1/15