MEDICAL INFORMATION

Today's Date: _______ _____

Student Name: ____ **Birth Date:** ____________

Name of **Family Doctor**: **Phone**:

____ ______________________

Address of Doctor's Office:

____

Does Student have **ASTHMA**? (Check one) Yes ___ No ___

*(**If yes,** please fill out "Student Asthma Action Card" form obtained from office)*

____

Does Student have to take **medication** during the school hours? (Check one) Yes ___ No ___

*(**If yes,** please obtain "Authorization for Administration of Medication at School" form from office)*

HOSPITAL PREFERENCE

Do you have a preferred hospital? (Check one) Yes ___ No ___

Hospital preference ____

MEDICAL HISTORY

Date	Condition	Description

ALLERGIES

Type	Description

Date of last tetanus shot: ___________________________

Name of Family Dentist: ______________________________________ **Phone:** ______________

Address of Dentist Office: ______________________________________

IN CASE OF EMERGENCY CALL (Other than parents):

NAME:____Relationship to student ________________________

Phone: Home: ____________________Work: ______________________Cell: _________________________

This person has permission to pick up the above named child and take from DACS campus: YES ___ NO ___ (Check answer)

NAME: ____ Relationship to student: _____________________

Phone: Home:____________________Work:______________________Cell: _________________________

This person has permission to pick up the above named child and take from DACS campus: YES ___ NO ___ (Check answer)

(Revised 4/10)