Southwest Allen County Schools
MEDICAL INFORMATION

Grade: ____/Teacher: _____

Student Name: _____/_____ **M/F: ___ Birth Date**: _____
(last) *(first)*

Address: _____ **City**: _____ **Zip Code**: _____

Home Phone: _____ **Student lives with**: □ ***Both Parents*** □ ***Mom only*** □ ***Dad only*** □ ***Shared Custody***

Father's Name: _____ **Employment**: _____

Father's Home Phone: _____ **Work Phone**: _____ **Cell Phone**: _____

Mother's Name: _____ **Employment**: _____

Mother's Home Phone: _____ **Work Phone**: _____ **Cell Phone**: _____

IN CASE OF ILLNESS OR EMERGENCY, FIRST CONTACT IS MADE TO THE PARENT(S). Please list two contacts other than parents for emergency situations.

#1 Name: _____ **Phone**: _____ **Relationship**: _____

#2 Name: _____ **Phone**: _____ **Relationship**: _____

Medical Information for School Personnel

❑ **My child has no medical problems that impact the school day.**

Please list any medication your child is currently taking:

Medication	Dose	Time

List any ***severe/life threatening*** allergies that require medication.

		Please list specifics
❑Food	❑Needs Epi-Pen	_____
❑Insect/Bee	❑Needs Epi-Pen	_____
❑Medications	❑Needs Epi-Pen	_____
❑Other		_____

Please check the boxes if your child has any of the following issues:

❑ADD/ADHD
❑Allergies non-life threatening
Type_____
❑Asthma ❑has inhaler
❑Autism
❑Cystic Fibrosis
❑Cancer Type _____
❑Diabetes ❑Type I ❑Type II
❑Head Injury/Concussion date: _____
❑Migraines with prescription medication
❑Seizure Disorder ❑Needs Diastat
❑Psychological/Emotional Disorder
❑Sickle Cell ❑disease ❑trait
❑Other _____
_____

Is physical activity restricted? ❑Yes ❑ No

If yes in what way? _____

Does the student have a 504 or an IEP? ❑Yes ❑No

Child's Primary Physician: _____
Physician's Phone Number: _____

Individual Health Plans should be in place for students with Asthma, Diabetes, Seizures and Severe Allergies. Some of these Health Plans require the signature of a physician. To ensure the safety of your child, please contact your school nurse as soon as possible to complete these plans.

Consent for Medical Treatment of a Minor Child (This form MUST be signed by a parent/guardian for the current year)

I (We) do hereby state that I am (we are) the parent(s) or legal guardian(s) of the above named student. I (We) realize that my (our) child, while attending school or participating in extracurricular events or field trips sponsored by or attended by his/her school, may become injured or ill to a degree which would require emergency medical attention. In the event of a serious medical emergency and none of the designated contacts can be reached, the above named student may be transported to the emergency room of the nearest hospital to receive medical treatment beyond what can be provided at school. I (We) authorize **DR. JOSHUA ST. JOHN** Principal of **SUMMIT MIDDLE SCHOOL**, or her designee (an adult over 18 years of age) to consent to any necessary examination, anesthetic, medical diagnosis, surgery or treatment, and/or hospital care to be rendered to the above-named minor under the general or special supervision and on the advice of any physician or surgeon licensed to practice medicine in the State in which the event is being held. This consent for medical treatment will remain in effect for the **2017-2018 SCHOOL YEAR.**

Parent/Guardian Signature: _____Date: _____