



Nursing Department – Mandatory Medical Form
(One form must be completed per child)

Student Information:			
Date: ____ / ____ / ____	Grade: ____	Date of Birth: ____ / ____ / ____	
Student Name: _____ / _____			
Last	First	Middle	Preferred Name
Parent/Guardian Names: _____			
Home Phone: _____		Mother Cell: _____	
E-Mail: _____		Father Cell: _____	
Mother Work: _____		Father Work: _____	
Preferred Contact Method: <input type="radio"/> E-Mail <input type="radio"/> Cell Phone <input type="radio"/> Work Phone			
Emergency Contact Person: _____			Phone: _____
Drug Allergy(s): <input type="radio"/> None Known <input type="radio"/> Yes (List): _____			
Primary Physician: _____			Office Phone: _____

My child has NO KNOWN MEDICAL CONDITIONS. (You may stop here, if there are no known medical conditions and your child does not need medicine at school. *Please sign at the bottom and return.*)

Student Medical Information:			
<input type="radio"/> Asthma	Triggers:	<input type="radio"/> Environmental/Seasonal	<input type="radio"/> Exercise
		<input type="radio"/> Other: _____	<input type="radio"/> Upper Respiratory Infection
	Does student need inhaler available at school?	<input type="radio"/> Yes (Requires Medication Consent)	<input type="radio"/> No
	Inhaler Location:	<input type="radio"/> Health Room <input type="radio"/> Classroom	<input type="radio"/> Student (Requires Self-Carry Form)
<input type="radio"/> Diabetes	<input type="radio"/> Type I <input type="radio"/> Type II	Date Diagnosed: _____	Insulin By: <input type="radio"/> Pump <input type="radio"/> Injections
	Is student independent with care?	<input type="radio"/> Yes <input type="radio"/> No	
<input type="radio"/> Allergies	Food:	<input type="radio"/> Peanuts <input type="radio"/> Tree nuts <input type="radio"/> Milk	<input type="radio"/> Others: _____
	Severe Sting:	<input type="radio"/> Bees <input type="radio"/> Wasps <input type="radio"/> Ants	<input type="radio"/> Others: _____
	Please list type of reaction: _____		
	** Notify your school nurse & teacher(s) if anaphylaxis may occur, & bring medication with consent by first day of school.		
<input type="radio"/> Seizure Disorder	(Explain): _____		
<input type="radio"/> Does your child have a history of head injury/concussion in the last year?	(Explain): _____		
<input type="radio"/> ADHD, ODD, Anxiety	(Explain): _____		
<input type="radio"/> Other Conditions:	_____		
Does your child take any routine medication(s)? <input type="radio"/> No <input type="radio"/> Yes List medications: _____			
Does your child need medication(s) at school? If your child needs medications at school, please provide the appropriate medication and consent forms. The medication policy and consent forms may be found on the Union Academy website or contact your school nurse.			
<input type="radio"/> No <input type="radio"/> Yes List medications: _____			

The information in this form is accurate to the best of my knowledge & I give permission to the School Staff/School Nurse to share information regarding my child's medical condition(s) with pertinent school employees, my physician or emergency personnel. I also give Union Academy permission to call 9-1-1 & have my child transported to a hospital if emergency care is needed.

Parent/Legal Guardian: _____ **Date:** _____

Signature