

CLAWSON PUBLIC SCHOOLS
Medical History

Student's Name: _____ Grade: _____

1. Emergency medical conditions/problems: check all that apply

- | | | |
|---|---|--|
| <input type="checkbox"/> Peanut Allergy # | <input type="checkbox"/> Bee Sting Allergy # | <input type="checkbox"/> Other Allergy (list below) |
| <input type="checkbox"/> Diabetic # | <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Asthma # |
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Seizure Disorder # | <input type="checkbox"/> Nose Bleeds |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Takes medication regularly * | <input type="checkbox"/> Other Medical Conditions (list below) |

If checked, a medical plan must be on file in your child's school office.

*Please indicate medication and how often taken _____

If taken during school hours, please contact school and obtain an Authorization for Medication form to be completed by the student's physician and parent or guardian.

2. Does your child have any of the following which might influence his school adjustment?

- Vision Deficiency _____ Hearing Deficiency _____ Speech Problem _____ Psychological _____
Glasses/contacts _____ Neurologic _____ Other _____

3. Is there any physical impairment or illness which should restrict your child's activities in any of the following?

- Classroom activities _____
Gym _____ Competitive Athletics and Sports _____

4. Is your child under medical care for any of the conditions specified above?

- Yes _____ No _____ Doctor's Name _____ Phone _____

5. AdditionalComments: _____

I understand that **written orders from my child's doctor** must be given to the school if my child needs to take medication during school as well as **all required medical plans** (as indicated above) will be submitted to the school.

In the event of a serious accident, injury, or medical condition, and I am unable to be reached, I authorize school personnel to call 911 to treat and/or transport my child to the nearest emergency facility where he/she may be treated by a licensed physician until I may be reached. I will not hold Clawson Schools responsible for emergency expenses incurred.

Signature: _____ Date: _____
Parent/Guardian