CLAWSON PUBLIC SCHOOLS
Medical History

Student's Name: _____ **Grade:** _____

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

___ Peanut Allergy # ___ Bee Sting Allergy # ___ Other Allergy (list below)

___ Diabetic # ___ Heart Condition ___ Asthma #

___ ADD/ADHD ___ Seizure Disorder # ___ Nose Bleeds

___ Headaches ___ Takes medication regularly * ___ 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

03/28/2012