Wickliffe Elementary School

Medical Information

Student's Legal Name:____

Last First Middle

Date of Birth:____________________ Gender: ___ M __ F

Grade:_______

My child has:

__Asthma __ Diabetes ____ Heart Disease __Seizures ____Other ___________

____

Allergies: __ Yes ___ No

List:____

____

List any specific instructions for allergic reactions: ____

____

____

Medications: (*List all medications your child is currently taking):*____________________________

____

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My child require: (*Circle all that apply*)

Glasses Contacts Hearing Aids Other_______________

List additional health problems:____

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I understand that students are not allowed to carry any type of medication on their person during the school day. Medications must be given to the office upon the student's arrival at school.

If medication is to be administered at school, a parent authorization form must be signed.

Parent/Guardian Signature: ________________________________
Date:_____________________
Revised 4/14/11