SCCS

ST CLAIR COUNTY SCHOOLS

MEDICAL FORM

Name of Student (First.Middle,Last)________________________________

Grade: _______ Homeroom Teacher: ________________________________

Date of Birth ______________________ Age _________ Social Security # _________________________

Address ____

Home Phone # ____

EMERGENCY CONTACTS
List any person(s), including parents/guardians, that may take your child in case of a medical emergency. Your child will not be released to any person not listed. Proper identification must be provided to pick up student from school.

Name/Relation to Student	Home Phone	Work Phone	Cellular Phone
(mom)			
(dad)			

HEALTH INFORMATION – Check all that apply to student

Allergies:

☐ Medicine ☐ Bees ☐ Ants ☐ Foods/Other

Health Problems:

☐ Asthma ☐ Diabetic ☐ Heart Problems ☐ Epilepsy/Seizures
☐ Eye Problems ☐ Ear Problems ☐ Nose Bleeds ☐ Bleeding disorders
☐ Blood Diseases ☐ Operations & broken bones ☐ Other

Any other medical conditions? ☐ Yes ☐ No
Any restrictions limiting physical activity? ☐ Yes ☐ No

If you checked any of the boxes above, please describe in detail any of these conditions: __________________________

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If your child has any conditions that limit his/her activity, a note from your doctor will be required to be excused from PE.

List any medication(s) your child takes on a regular basis: ________________________________

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In order for your child to take any medication at school, a state required form must be completed before any medications can be administered. The medication must be delivered by the parent in the original container. If it is a prescription, ask your pharmacist for a second bottle for the school. If the medicine is over the counter, the medicine must be in the original container with the student’s name, dosage, and time the medication is to be dispensed.

*****ALL MEDICATION MUST BE DELIVERED TO THE SCHOOL BY AN ADULT PARENT/GUARDIAN.*****

PLEASE COMPLETE BACK PAGE OF THIS FORM.

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MEDICAL FORM (2)

I give my permission to have my child treated by the school nurse and administered first aid. I understand that all reasonable precautions will be taken for my child's safety, and I will not hold the school or employees responsible for any illness or unforeseen accident.

Student's Doctor Phone Number of Doctor

Address of Doctor

Hospital Choice

Insurance Company Insurance Number

I, the undersigned, do hereby authorize the officials of the St. Clair County School System to contact directly the persons named on this paper, and to authorize the named physician(s) to render such treatment as may be deemed necessary in an emergency, for the health of my child. In the event that the physicians(s), other persons named on this paper, or parents cannot be contacted, the school officials are hereby authorized to take whatever action is deemed necessary, in their judgment, for the health of my child. I will not hold the school financially responsible for the emergency care and/or transportation of my child. Every attempt will be made to reach the parent or emergency contact person listed.

I agree to allow the school nurse to exchange medical information with physician, dentist, physician assistant or emergency medical personnel in order to provide medical care for my child.

Signature of Parent/Guardian

Please notify the school nurse of any changes in health status, new surgeries, or special needs for your child.