School Year__________ School ____________________________Grade_____Teacher____________

# CONFIDENTIAL STUDENT MEDICAL HISTORY INFORMATION

*(To be completed by Parent or Guardian. Use the back of this form if more space is needed)*

**Student Name**_________________________________ **Date of Birth**____________________

**Address** ______________________________________________________________________

**Father** ______________________________________ **E-Mail** _________________________

**Phone: (Home)**________________**(Work)**________________**(Cell)**________________

**Mother** ______________________________________ **E-Mail** _________________________

**Phone: (Home)** ________________ **(Work)**________________**(Cell)**________________

**Legal Guardian** _______________________________ **E-Mail** _________________________

**Phone: (Home)**________________**(Work)**________________**(Cell)**________________

**Other:** ______________________________________ **E-Mail** _________________________

**Phone: (Home)**________________**(Work)**________________**(Cell)**________________

Is this student presently under a physician's care? _______ Describe: ____________________________

______________________________________________________________________________

Physician Name Address Phone

1. Is the student currently taking any medication? ______ *If yes, please list drug, dose, and time given:*

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

***2. If the student will be taking medication at school, please contact your school nurse or office for guidelines.***

3. Does this child have any medical or physical problem the school should know about? (Tires easily, allergies, headaches, nosebleeds, handicaps, etc.)

______________________________________________________________________________

4. Does this student have **asthma*** as diagnosed by a physician? No _____ Yes_____* *If yes, please contact your school nurse for the appropriate forms for the physician plan of care.*

5. Has this student had any allergic reactions to medications, **foods*, insects*, or other***? No ______Yes_____ *If yes, please contact your school nurse for the appropriate forms for the physician plan of care.*
*If yes, the student is allergic to:* _____________________________________________
*The treatment for the above allergy is:* __________________________________________
*Is an EpiPen* prescribed? Yes______ No______ If yes, Epipen must be provided by parent to be kept at school.*

6. Does this student have a **seizure disorder*** as diagnosed by a physician? No ______Yes_____* *If yes, please contact your school nurse for the appropriate forms for the physician plan of care.*
*If yes, please list medication, amount and time given*___________________________________
*Is Diastat or other Emergency Drug prescribed? No ______ Yes______*

7. Has this student been diagnosed by a physician as having any kind of bleeding tendency? No _____Yes_____ *If yes, please contact your school nurse for the appropriate forms for the physician plan of care.* If yes, please describe______________________________________________________________

8. Does this student have **diabetes?*** No______ Yes*______
*If yes, please contact your school nurse or office for guidelines and the appropriate forms for the physician plan of care.**

9. Does this student wear glasses? No______ Yes______ Contact Lenses? No______ Yes______

10. Has this student had chicken pox? Yes ____ No ____ (If yes, approximate date: _________________)

I have read the terms of the Indiana Department of Health Children and Hoosiers Immunization Registry Program (CHIRP) and agree to MCS utilization.
In case of Emergency, illness, or accident to the student named above, if emergency contacts cannot be reached, Madison Consolidated Schools staff has permission to notify EMS and transport to Kings Daughters Hospital. If my child exhibits signs of an allergic reaction while at school, MCS staff has permission to administer Benadryl.

Guardian Signature_____________________________________________Date_____________