



## 2008/2009 Student Medical Alert Update

\_\_\_\_\_  
(Last)

\_\_\_\_\_  
(First)

\_\_\_\_\_  
(MI)

\_\_\_\_\_  
(Grade)

Health History: Please complete this form. This information is considered **CONFIDENTIAL** and will be available to health room staff, your child's teacher(s), building administrators and others as needed to ensure your child's safety and protection at school.

Health Concerns (please name concern/specify dates and add any pertinent details)

Allergies (i.e., bee, food, medication):

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Health conditions (e.g., asthma, seizure disorder, physician confirmed migraine headaches, diabetes):

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Medications (currently taking):

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Other:

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### PHYSICIAN INFORMATION:

Child's doctor: \_\_\_\_\_ Phone #: ( ) \_\_\_\_\_

Clinic name (if applicable): \_\_\_\_\_

Address: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_