Child's School & Medical Information

Child's Name: _____ Date of Birth: _____

Parent/Guardian: _____

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School Information

Resource ☐ Regular Education ☐ 504 Plan ☐

School Name: _____

Teacher Name: _____

Grade: _____

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Medical History & Medications

List all medications including over the counter medications that your child is currently taking

Medication	Dose	Duration

Check any of the following conditions which your child now has or has had in the past

	Allergies to medications		Closed head injuries with loss of consciousness
	Severe Headaches/migraines		Seizures
	Hyper/hypo thyroidism		Asthma
	Arrhythmias/heart problems		High Blood Pressure (hypertension)
	Diabetes		Hypercholesterolemia/hyperlipidemia
	Gastrointestinal conditions		Kidney problems
	Weight loss		Reduced growth
	Obesity		Chronic pain
	Cancer		Fractures
	Surgeries		HIV
	Hepatitis B/C		History of failure to thrive