Medical Information for 2017-2018

Student Name: _____

*IF YOUR CHILD HAS NO MEDICAL CONDITIONS, PLEASE WRITE "NONE" ON THE LINES BELOW. If you need more room to explain, please use the back side of this form.

My child has the following allergies/medical condition(s): _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

OTHER:

- ☐ My student wears glasses and/or contacts
- ☐ My student has asthma
    - If this box is checked, you will need to fill out an Asthma History Form
- ☐ My student has allergies
    - If this box is checked, you will need to fill out an Allergy History Form

Parent Signature: _____ Date: _____