New Kent County Public Schools

Medical Information - Clinic Record

Student's Name _____ Date of Birth: _____

Mailing Address _____
(Street) (City) (Sate) (Zip)

Home Telephone # (_____)_____ Grade: _____

Medical History

☐ Allergies (seasonal)_____
☐ Allergies (Food)_____
☐ Allergic Reaction Bee Sting (Severe)
☐ Allergic Reaction Bee Sting (Local Reaction)
☐ Asthma
☐ Diabetes
☐ Ear Infections
☐ Hypertension (high blood pressure)
☐ Psychiatric Disorder
☐ ADD/ADHD
☐ Cardiac Problems
☐ Hearing Impairment
☐ Seizure Disorder
☐ Other _____

Medication taken daily: _____

Reason for medication: _____

Special medical instructions: _____

Please list any health concerns: _____

*****REMINDER: No medication will be given unless provided by the parent in a properly labeled original container accompanied by a prescription form signed by both parent and physician or health care provider.**

☐ Please check here, if you do not have health insurance on your child and are interested in obtaining information.

Physician name: _____ Telephone # (_____)_____

Preferred hospital name: _____

I give permission to contact the physician or health care provider regarding my child's medical history or treatment: _____Yes _____No

In case of emergency, permission is given to transport my child to the doctor or hospital by car or rescue squad: _____Yes _____No

Signature of parent/guardian _____ Date _____