



**ANNUAL**  
**CONSENT FOR MEDICAL CARE**  
(Distributed to nurses' office, teachers, coaches, etc.)

**This form must be completed in ink. Please print or type all information**

Student's name \_\_\_\_\_ Grade \_\_\_\_\_  
Student's Date of Birth \_\_\_\_\_  
Address \_\_\_\_\_ City, zip \_\_\_\_\_  
Home Phone # \_\_\_\_\_  
Parent's/Guardian's Names \_\_\_\_\_  
Legal Custody belongs to: Both parents \_\_\_\_\_ Other \_\_\_\_\_

Local Emergency Contacts, complete all lines. Number by call priority.

\_\_\_\_ Parent, name \_\_\_\_\_ call this # 1st \_\_\_\_\_, 2<sup>nd</sup> # \_\_\_\_\_  
\_\_\_\_ Parent, name \_\_\_\_\_ – call this # 1<sup>st</sup> \_\_\_\_\_, 2<sup>nd</sup> # \_\_\_\_\_  
\_\_\_\_ Person to call if parent/guardian not available \_\_\_\_\_ Relationship \_\_\_\_\_  
    Call this # 1<sup>st</sup> \_\_\_\_\_, 2<sup>nd</sup> # \_\_\_\_\_  
\_\_\_\_ Person to call if parent/guardian not available \_\_\_\_\_ Relationship \_\_\_\_\_  
    Call this # 1<sup>st</sup> \_\_\_\_\_, 2<sup>nd</sup> # \_\_\_\_\_

Student's physician \_\_\_\_\_ Phone \_\_\_\_\_  
Student's dentist \_\_\_\_\_ Phone \_\_\_\_\_  
Student's Health Insurance. If none, state none. \_\_\_\_\_  
Policy Number \_\_\_\_\_ Insurance phone # \_\_\_\_\_

List all food allergies and reactions. If none, state, none. \_\_\_\_\_  
List other allergies (including drug allergies). If none, state none. \_\_\_\_\_  
Identify health concerns. If none, state none. \_\_\_\_\_  
List all current medications. If none, state none. \_\_\_\_\_

If my child is not feeling well during the school day, the school nurse or faculty member if the nurse is not available has parent permission to give over-the-counter medication, as appropriate, to my child according to the labeled instructions. Please initial.

Yes \_\_\_\_\_ No \_\_\_\_\_

For the school year, in the case of a health emergency, the school is authorized to call 911 and/or utilize the nearest emergency room. The doctor in attendance has my permission to proceed with any critical medical treatment required for my student. The school will make every attempt to contact the parent or guardian in the event of an emergency. The parent assumes full financial responsibility for any emergency care. Please initial.

Yes \_\_\_\_\_ No \_\_\_\_\_

**The above information is considered confidential. With the signatures below, families consent to the release of the above information on a need-to-know basis. Parent(s)/guardian(s) should sign below:**

Parent/guardian signature \_\_\_\_\_ Date \_\_\_\_\_

**To be completed by a parent/guardian. Please print all information.**

Student \_\_\_\_\_ Date of Birth \_\_\_\_\_ Grade \_\_\_\_\_

Please circle gender:    male    female

**MEDICAL HISTORY**

Allergies \_\_\_\_\_ Food allergy \_\_\_\_\_ Illness \_\_\_\_\_

Surgeries \_\_\_\_\_ Accident/ Injury \_\_\_\_\_

Is student taking **any** medication on a routine basis? Yes \_\_\_\_\_ No \_\_\_\_\_

List all medication : \_\_\_\_\_

Is student allergic to any medication?    Yes \_\_\_\_\_    No \_\_\_\_\_    Please list and describe reaction: \_\_\_\_\_

Has student consulted with a specialist in the past 5 years?

Yes \_\_\_\_\_ No \_\_\_\_\_    If yes, please describe nature of condition: \_\_\_\_\_

**This section to be completed by examining physician.**

**PHYSICIAN EXAMINATION :**

Height \_\_\_\_\_ Weight \_\_\_\_\_ BMI \_\_\_\_\_ Blood Pressure \_\_\_\_\_ Pulse \_\_\_\_\_

	Normal	Abnormal		Normal	Abnormal
General Appearance			Cardiovascular		
Skin			Gastrointestinal		
Eyes			Genito-urinary		
Ears/Nose/Throat			Neurological		
Mouth/Dental Assessment			Developmental Screening		
Muscular			Nutritional Assessment		
Skeletal			Respiratory		

Are there concerns for this student's health?

\_\_\_\_\_

Is the student capable of physical activity and participation in a competitive athletic program? \_\_\_\_\_ Yes \_\_\_\_\_ No

Are there any sports in which this student should not participate? \_\_\_\_\_

Are there any restrictions or activity limitations? \_\_\_\_\_

**SCREENING TESTS:**

Tuberculin test: Date \_\_\_\_\_ Positive \_\_\_\_\_ Negative \_\_\_\_\_    CSR date (if pos.): \_\_\_\_\_

Vision: Right 20/\_\_\_\_\_ Corrected to 20/\_\_\_\_\_ Left 20/\_\_\_\_\_    Corrected to 20/\_\_\_\_\_

**RECENT IMMUNIZATION DATES:**

Varicella: dose one \_\_\_\_\_, dose two \_\_\_\_\_    History of the disease: \_\_\_\_\_

Td/Dtap: \_\_\_\_\_    MMR: \_\_\_\_\_    HEP B: \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_    Polio: \_\_\_\_\_    HEP A \_\_\_\_\_, \_\_\_\_\_

Pneumonia (PCV7) \_\_\_\_\_

Results of the physical exam completed by me on this date indicate that the individual named above is in good health.

Any problems to the contrary have been noted above.

Date \_\_\_\_\_ Examining Physician Signature \_\_\_\_\_

Physician's Name \_\_\_\_\_ Phone \_\_\_\_\_