THE ROBERTS ACADEMY
AT FLORIDA SOUTHERN COLLEGE

2020-2021

MEDICAL INFORMATION FORM

I understand that it is my responsibility to notify the school of any changes in the information recorded on this form.

Teacher_____
Grade/Room_____

Student_____ **Male/Female**_____
Last First Middle

Birth Date_____ **Home Phone #**_____ **Cell Phone #**_____
MM/DD/YYYY

Address_____
Street City Zip

Mailing Address _____
(if different) Street/PO Box City Zip

FULL NAME	Home Phone	Cell Phone Or Beeper	Work Phone	Lives With?	OK to PickUp and Contact?
Parent/Guardian Name				Yes ___ No ___	Yes ___ No ___
Parent/Guardian Name				Yes ___ No ___	Yes ___ No___

Also list Parent/Guardian names and additional names of responsible adult contacts on the Emergency and Contact Information Form

Please circle any conditions that apply to your child. I understand and agree that certain educational records of my child may be shared with Florida Southern College's health care partners as needed to provide and evaluate health services to students. I also understand and agree that my child's medical treatment records created by health care personnel at school may be shared with school officials who have a legitimate educational purpose for accessing such treatment records.

1. Asthma/breathing problems
2. ADD/ADHD
3. Bladder problems
4. Bleeding problems
5. Bone/joint problems
6. Bowel problems
7. Cancer
8. Cystic fibrosis
9. Dental (tooth) problems/braces
10. Diabetes
11. Epilepsy/seizures
12. Headaches (severe)
13. Heart problems
14. Kidney problems
15. Mental health problems
16. Nosebleeds (frequent)
17. Sickle cell disease

Please explain any circled items or other serious surgeries, illnesses or injuries:_____

_____

_____

In your opinion, might any of the problems circled above, or any other medical condition your child has, affect his/her school performance, program or ability to participate in a regular physical education program? If yes, please explain:_____

_____

_____

Please list **allergies and reactions** and check the appropriate column stating the severity of each:	None	Mild	Moderate	Severe (needs meds)	Life Threatening (Call 911)
Insect stings/bites_____					
Food/Plants/Other_____					
Medicines_____					

If your child has asthma, has it been diagnosed by a doctor? Yes_____ No_____ If yes, what treatment has been prescribed?
_____Inhaler _____Nebulizer _____Other, please list:_____

Will your child be taking any medications, either prescriptions or over-the-counter, or require any medical treatments at school? Yes_____ No_____
If yes, please list:_____

If yes, parent must provide a new Authorization for Medication form each school year. All medications must be brought to school by an adult.

_____ _____
Parent Signature Date

Created: 5Feb10; 25June10