

MEDICAL INFORMATION



Student Name: _____ Birth Date: _____

Name of Family Doctor: _____ Phone: _____

Address of Doctor's Office: _____

Does Student have **ASTHMA**? Yes No
(If yes please fill out "Asthma Individual Health Plan" form obtained from office)

Does Student have to take **medication** during the school hours? Yes No
(If yes please obtain "Authorization for Administration of Medication at school" form from office)

MEDICATION PERMISSION

The school secretary, or other designated school personnel, has my permission to administer Tylenol to my child on an as-need basis. **Circle one:** Yes No

Parent's Signature Authorizing Permission to Administer Tylenol

Name of Family Dentist: _____ Phone: _____

Address of Dentist Office: _____

MEDICAL HISTORY

Date	Condition	Description	Note

ALLERGIES

Type	Description	Note

IN CASE OF EMERGENCY CALL (Other than Parents):

NAME: _____ Relationship to student _____

Phone: Home: _____ Work: _____ Cell: _____

This person has permission to pick up the above named child and take from LCAS campus: YES NO (circle answer)

NAME: _____ Relationship to student: _____

Phone: Home: _____ Work: _____ Cell: _____

This person has permission to pick up the above named child and take from LCAS campus: YES NO (circle answer)