2017-2018 Student Medical Information

Medical Updated Date _____

Last Name _____ First Name _____ Birth Date _____

Required by the Ohio Department of Education:

Physician _____ Physician Phone _____ Last Physicial Exam _____

Dentist _____ Dentist Phone _____ Last Dentist Exam _____

Eye Dr _____ Eye Dr Phone _____ Last Eye Exam _____

☐ Permission to Transport to Hospital Refusal Actions _____

Diagnosis _____

Allergies/Treatment _____

Diets _____

Chronic Physical Problem _____

Hospitalizaiton History _____

Diseases _____

☐ Medications Medication Comments _____

Medication _____ Dosage _____ Time Given _____

Medication _____ Dosage _____ Time Given _____

Medication _____ Dosage _____ Time Given _____

Medication _____ Dosage _____ Time Given _____

Medication _____ Dosage _____ Time Given _____

Medication _____ Dosage _____ Time Given _____

Check any/all that apply:

☐ Has Seizures ☐ Knows Sign Language ☐ Wheelchair

☐ Non Verbal ☐ Is Hearing Impaired ☐ Harness

☐ Limited Verbal ☐ Is Visually Impaired/Blind

Other _____

I give my permission for medication to be given to the above individual while at school (if applicable) and agree to notify the WCBDD program nurse of any changes in physician's instructions of treatment or if medication or treatment is discontinued. In the event of a severe reaction, the WCBDD program nurse will be

_____ _____

Parent/Guardian Signature Date