COOLIDGE UNIFIED SCHOOLS MEDICAL INFORMATION CARD
(Please print. Both sides must be completed)

Name:_____ Birth Date:_____ Sex: M_____ F.____
(Last) (First) (Middle)
Teacher:_____ Grade:_____ Was child previously enrolled in Coolidge School District? Y____N___

Street Address:_____ City:_____ Zip:_____

Mailing Address:_____ City:_____ Zip:_____

Home Telephone Number: (_____)_____ Has child ever been enrolled in Special Education or had an IEP?_____

PERSONS TO BE CALLED IN AN EMERGENCY

(Please update phone numbers when changes occur)

Father: _____ Work Phone (_____)_____ ext_____ Cell_____

Mother: _____ Work Phone (_____)_____ ext_____ Cell_____

Guardian/Stepparent:_____ Work Phone (_____)_____ ext_____ Cell_____

Name of person that can be contacted and check student out of school in the event parents cannot be contacted:

Name:_____ Relationship:_____ Phone: (_____)_____Cell_____

Name:_____ Relationship:_____ Phone: (_____)_____Cell_____

Insurance/AHCCCS: _____ ID Number:_____ Doctor:_____

I give my permission to Coolidge Unified School District #21 to treat my child for emergency health needs. I am to be notified in case of an emergency and on other occasions when the school feels it is necessary. I understand that I am financially responsible if outside medical assistance is utilized.

_____ _____
Parent Signature Date

The following medications are kept in the health office. Please indicate which medications your child may receive:

Yes	No	
___	___	antacids (for stomach aches, indigestion, diarrhea)
___	___	acetaminophen (for headaches, pain)
___	___	ibuprofen (for headaches, pain)
___	___	eye drops or wash (for eye irritation)
___	___	throat lozenges or spray, topical oral anesthetics (for sore throat, mouth pain cough)
___	___	topical ointments, salves, sprays and anesthetics (for cuts, scrapes, rashes, skin irritations, burns)

Does your child have any allergies to medications? Yes_____ No_____ To What:_____

IF A CHILD BRINGS MEDICATION TO SCHOOL, IT MUST BE KEPT IN THE HEALTH OFFICE. THIS PERTAINS TO BOTH PRESCRIPTON AND NON-PRESCRIPTION MEDICATION. ALL MEDICATION MUST BE IN THE ORIGINAL PHARMACY CONTAINER. PLEASE SEND A NOTE WITH YOUR CHILD GIVING THE NURSE PERMISSION TO ADMINISTER THE MEDICATION.

HEALTH HISTORY

Please check whether your student has had, or currently has, any of the listed problems and indicate if they are being treated by a doctor for that condition.

Present Past Dr. Care

_____ _____ _____ allergy to what:_____ what type of reaction_____ Medication taken_____
_____ _____ _____ anemia
_____ _____ _____ arthritis
_____ _____ _____ attention deficit disorder (ADHD, ADD) Medication:_____

_____ _____ _____ asthma Hospitalization?_____ Medication:_____
_____ _____ _____ bladder problems
_____ _____ _____ chickenpox date/age_____ Only students who entered school or childcare in Arizona prior to 9/1/2011 with parental recall of chicken pox disease are allowed to continue attending school in Arizona without proof of varicella immunization or exemption. After 9/1/2011 children whose health care providers can document their history of chicken pox need to obtain a medical exemption signed by the physician
_____ _____ _____ concussion

_____ _____ _____ diabetes Type_____ Medication:_____
_____ _____ _____ eczema
_____ _____ _____ ear infections (frequent) surgery type and dates_____
_____ _____ _____ eye problems
_____ _____ _____ emotional problems Medication:_____

_____ _____ _____ epilepsy (seizures) type_____ how often_____ Medication:_____
_____ _____ _____ fainting (frequently)
_____ _____ _____ fractures resulting in surgery Nature and year_____
_____ _____ _____ heart murmur
_____ _____ _____ hepatitis Type A_____ Type B_____ Type C_____

_____ _____ _____ hernia where_____ Surgical repair date:_____
_____ _____ _____ hives
_____ _____ _____ kidney trouble
_____ _____ _____ menstrual cramps (severe)
_____ _____ _____ migraine headaches
_____ _____ _____ mononucleosis
_____ _____ _____ pregnancy delivery/ due date_____
_____ _____ _____ sinus trouble (severe)
_____ _____ _____ sore throats (chronic)
_____ _____ _____ urinary tract infections
_____ _____ _____ other_____

List any surgeries or hospitalizations and approximate dates: _____

List any other medications taken on a regular basis including inhalers, behavior medication and birth control pills:
_____

Does your child wear glasses_____ Full time____ Part time_____ contacts_____ Date of last eye exam:_____
Does your child have any hearing problems? Describe _____
Does your child have hearing aids?_____ Date of last hearing exam:_____

(rev 2/14 bbm)