CHOCTAWHATCHEE HS STYLE MARCHERS

MEDICAL INFORMATION FORM

Student Name: _____

Grade: _____ Style Marcher Section: _____

EMERGENCY CONTACT INFORMATION

Name (Primary): _____

Relationship: _____

Phone(s): _____

Name (Secondary): _____

Relationship: _____

Phone(s): _____

ALLERGIC HISTORY

- **MEDICATION** Allergy? If **YES**, please describe. ☐ YES ☐ NO
  _____
- **INSECT** Allergy? If **YES**, please describe. ☐ YES ☐ NO
  _____
- **OTHER** Allergy (e.g., food)? If **YES**, please describe. ☐ YES ☐ NO
  _____

CONDITION OR ILLNESS

- Does the student have a chronic or ongoing condition for which he/she is being treated or undergoing evaluation? If **YES**, please describe. ☐ YES ☐ NO
  _____
  _____

CURRENT MEDICATIONS

- If **YES**, please list. Include all prescribed and over-the-counter medications. ☐ YES ☐ NO
  _____
  _____

SPECIAL EQUIPMENT

- Does the student require the use of special equipment (e.g., glasses, wrist brace, etc.)? If **YES**, please list. ☐ YES ☐ NO
  _____
  _____

SPECIAL NEEDS

- Are there any physical/emotional needs which the nursing/medical personnel should be aware of? If **YES**, please list. ☐ YES ☐ NO
  _____
  _____

OVER-THE-COUNTER MEDICATIONS

- Please check "OK" and INITIAL if you wish to give permission for Nursing/Medical personnel to administer over-the-counter medications (e.g. Tylenol, Dramamine, Pepto Bismol, cough drops, etc.) when needed? ☐ OK INITIAL HERE _____
- Are there any exclusions, restrictions or concerns about over-the-counter medications for your student? If **YES**, please list. ☐ YES ☐ NO
  _____

PARENT SIGNATURE: _____ DATE: _____

Revised 7.4.20