Student Name:_____DOB_____

Please check YES or NO to the following. Does your child have or has your child ever had:
(**If yes, please explain and give the date of diagnosis/date of last event**.) *EAP needed

YES	NO	
___	___	***Diabetes**_____ (if Glucagon is prescribed parent/guardian must provide)
___	___	***Asthma**_____ (if inhaler/nebulizer is prescribed parent/guardian must provide)
___	___	***Seizures/convulsions** _____ *If yes, does your child require Diastat for seizures lasting longer than 5 minutes?____ (if Diastat is prescribed parent/guardian must provide)
___	___	Fainting _____
___	___	Cardiovascular (heart) disease _____
___	___	High blood pressure _____
___	___	Head or spinal injuries _____
___	___	Kidney disease _____
___	___	Hepatitis or other liver disease _____
___	___	Migraines/Frequent headaches _____
___	___	Anxiety/Panic Attacks _____
___	___	Nervous Stomach _____
___	___	Scoliosis _____
___	___	Psychiatric disorder _____
___	___	Emotional or behavioral disorder _____
___	___	Eye/vision deficit _____
___	___	Wears glasses/contacts _____
___	___	Hearing deficit/hearing aid _____
___	___	Permanent defect from any illness, disease, or injury _____
___	___	Past surgeries _____

The following First-Aid supplies are kept on hand in each clinic.
Please indicate with a check those that may be used for your child as needed.

_____Alcohol Pads	_____ Bandaids (Latex)	_____ Bactine
_____Caladryl	_____ Latex Gloves	_____ Aloe
_____Hydrogen Peroxide	_____ Antibiotic Ointment	_____Vaseline

I hereby authorize school officials to obtain emergency medical care for my child.

X_____ _____
Signature of Parent/Guardian Date